THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

SEP 24 2002

The Honorable J. Dennis Hastert
Speaker of the House of Representatives
Washington, DC 20515

Dear Mr. Speaker:

I am pleased to forward the enclosed report that responds to Section 723 of the National Defense Authorization Act for Fiscal Year 2000. Section 723 requests the Assistant Secretary of Defense for Health Affairs to submit an annual report on the quality of health care furnished under the health care programs of the Department of Defense. The time frame of the report is to cover the most recent fiscal year, in this case, Fiscal Year 2001.

The report contains a discussion of health outcomes, the use of health report cards, the use of standard clinical pathways, and innovative processes for surveillance. The report also highlights the extraordinary initiatives in the area of detection of waste, fraud and abuse.

Thank you for your continued interest in and support of the Military Health System.

Sincerely,

William Winkenwerder, Jr.

William Winkenwerder, Jr., MD

Enclosures:
As stated

Department of Defense
Report to Congress

Quality of Health Care Furnished under the Defense Health Program During FY 2001

Cervical Cancer Screening *

Prenatal Care in First Trimester *

Best Clinical Practices

Preventable Admission Rates for Nine Diagnoses

Follow-up after Hospitalization for Mental Illness *

Check-ups after Delivery *

Eye Exams for Diabetics *

Beta Blocker after Heart Attack *

Asthma Management *

Best Business Practices

Outpatient Visists/1000 Prime Enrollees

Specialty Referrals (Consultations)/1000 Prime Enrollees

Discharges/1000 Prime Enrollees

Average Length of Stay for Prime Enrollees

Emergency Room Visits/1000 Prime Enrollees

Percent External Customer Workload – Space A

SADR to MEQS Visit Comparison

Prime MTF Enrollee Visits in Network/1000 MTF Enrollees

Financial Performance PMPM/PMPY

Each* BCP and PHI measure uses two Enrollment concepts

Continuous = enrollment time period specific to each measure

Non-continuous = Enrollment as of the last month of the observation period

Population Health Operational Tracking and Optimization Metrics

(PHOTO)

Original PHOTO Metrics Identified by the TriService Metrics Workgroup, NOV 1999

5.3.1 Breast Cancer Screening (HEDIS Measure)

5.3.2 Cervical Cancer Screening (HEDIS Measure)

5.3.3 Prenatal Care in the First Trimester (HEDIS Measure)

5.3.4 Childhood Immunization Status (HEDIS Measure)

5.4.1 Eye Exams for Diabetes (HEDIS Measure)

5.4.2 Follow-up for Hospitalization for Mental Illness (HEDIS Measure)

5.4.3 Checkup after Delivery (HEDIS Measure)

5.4.4 Beta Blocker Treatment after a Heart Attack (HEDIS)

5.4.5 Asthma Management

5.4.6 Preventable Admission Rates for Prime Enrollees for Nine Diagnoses Identified in the ASD/HA Performance Contract

5.5.1 Outpatient Visits per Member per Month (PMPM)/per Member per Year (PMPY)

5.5.2 Specialty Referrals PMPM/PMPY

5.5.3 Pharmacy Cost PMPM/PMPY

5.5.4 Discharge per 1000 Enrollees

5.5.5 Average Length of Stay (MTF enrollees only)

5.5.6 Emergency Room (ER) Visits/1000 MTF Enrollees

5.5.7 Percent of Users Enrolled in Catchment Areas

5.5.8 PMPM Financial Metric

5.5.9 World Wide Workload (WWR) to SADR Visit Count Percentaged

Current PHOTO Measures

Customer Satisfaction

Overall Satisfaction with Care Received at MTF

Wait Time at Appointment Standard

Wait Time for Appointment Standard

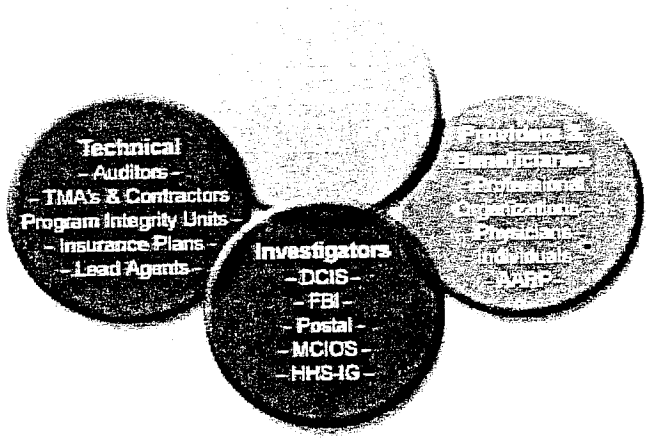
Population Health Improvement

Breast Cancer Screening*

TRICARE Fraud & Abuse

Welcome

The Program Integrity Office at the TRICARE Management Activity (TMA) in Aurora, Colorado, is the central coordinating agency for allegations of fraud and abuse within the TRICARE program.



This office is committed to preventing, identifying, and assisting in the prosecution of health care fraud, not only to save valuable benefit dollars but also to ensure that eligible beneficiaries receive appropriate medical care. Fraud schemes can adversely impact the quality of the care received.

From this Web site, we will disseminate information on fraud news, frequently asked questions, data on providers who have been sanctioned, and fraud referrals by contractors.

An important part of the TRICARE Fraud Watch program involves sharing information. This Web site has been designed for just that purpose.

Where do you report suspected fraud?
Write to: MCS Contractor's Program Integrity Office
Call contractor's "800" number
or
TRICARE Management Activity
Attn: Program Integrity
16401 East Centretech Parkway
Aurora, Colorado 80011-9043
or
Fax: (303) 676-3981

- Inpatient neonatal mortality – live-born infants who expire less than 29 days after birth (stratified by birth weight)
- Third or fourth degree laceration – patients who have vaginal deliveries with third or fourth degree perineal laceration (risk adjusted)

JCAHO ORYX

Core Measure Sets

Acute Myocardial Infarction

- Reperfusion therapy – time from arrival to initiation of thrombolytic medication
- Reperfusion therapy – time from arrival to initiation of primary percutaneous transluminal coronary angioplasty (PTCA)
- Smoking cessation/advice/counseling
- Aspirin at arrival
- Aspirin prescribed at discharge
- Patients with Left Ventricular Ejection Fraction (LVEF) < 40 percent prescribed angiotensin converting enzyme inhibitors at discharge
- Beta blocker prescribed at discharge
- Inpatient mortality (risk adjusted)
- Beta blocker at arrival

Heart Failure

- Heart failure patients with complete discharge instructions in the medical record
- Heart failure patients not admitted on angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blockers (ARB) with LVEF evaluated before or during hospitalization, or planned after discharge
- Patients with LVEF < 40 percent prescribed ACEI at discharge
- Smoking cessation advice/counseling

Community Acquired Pneumonia (CAP)

- Oxygenation assessment within 24 hours of hospital arrival
- Inpatients screened for and/or given pneumococcal vaccination
- Blood cultures obtained prior to first antibiotic administration
- Time from initial hospital arrival to first dose of antibiotic
- Adult CAP smoking cessation counseling
- Pediatric CAP smoking cessation counseling

Pregnancy Measures

- Vaginal birth after cesarean section (risk adjusted)

information on the web page and rapid ability to contact subject matter experts, C& CS staff provided accurate and timely answers to a myriad of questions.

Later in the year, 15 percent of these calls came from beneficiaries over 65 years of age regarding the new TRICARE for Life benefits. They sought answers to program, benefits, claims processing, and other health insurance questions. The second highest category of inquiry (12 percent) consisted of claims questions or requests for assistance in getting claims issues answered. Staff continuously provided assistance to Active Duty, Retirees and family members in addressing enrollment status questions, pharmacy and dental program changes, provider access, as well as many other concerns.

Department of Defense Worldwide –TRICARE Information Center (W-TIC)

In May 2001, C& CS established new TRICARE toll-free telephone numbers to link beneficiaries to representatives with answers about TRICARE for Life, the TRICARE Senior Pharmacy Program, and TRICARE Prime Remote for active duty and their family members. These telephone numbers greatly expanded TRICARE's ability to provide accurate information and resolve problems. The DoD W-TIC handled 1,564,710 phone calls from 31 July 2001 through 28 December 2001 (1,129,328 inbound calls and 435,382 outbound calls). The toll free calls center identified the following top categories of calls:

- Issues with other health insurance;
- Crossover of claims from Medicare to TRICARE;
- Requests for general information;
- Eligibility-related issues; and,
- Electronic-health (e-health) process questions.

Live, non-recorded representatives stay on-line with all of the callers until they answer the beneficiary's questions or link the beneficiary to appropriate subject matter experts that can provide definitive problem resolution assistance.

From the external MHS customer's point of view, "Team Customer Service" created and developed a cutting-edge web-based application that enhanced debt collection case monitoring and trending on a global basis. The proactive partnering with the Lead Agent DCAOs resulted in an effective deployment of the web-portal to more than 300 locations worldwide. This tool significantly reduced the man-hours expended by 40 percent and received accolades from users at all levels.

Beneficiary Counseling and Assistance Coordinator Program

In response to Section 715 of the National Defense Authorization Act for Fiscal Year 2000, 10 U.S.C section 1095e, C&CS standardized the Beneficiary Counseling and Assistance Coordinator (BCAC) roles and responsibilities. Beneficiary Counseling and Assistance Coordinators directly assist with TRICARE program and policy, access, reimbursement, or TRICARE benefit plan coverage issues or questions. The BCACs are full-time positions within Lead Agent Offices and either primary or collateral duty positions within military treatment facilities. They expand the communication network available to beneficiaries and serve to consistently render help to them in understanding TRICARE and resolving their concerns.

Medal Of Honor Program (MOH)

The National Defense Authorization Act for 2001 expanded the TRICARE healthcare benefit to Medal of Honor recipients and their family members. Therefore, the CS&C staff targeted all MOH recipients for direct mailing of information about this change in healthcare coverage. They coordinated with Lead Agent staff and identified a personal point of contact for these recipients. For the first time, TMA presented information about program enhancements at the National Medal of Honor Society Convention. The speaker received recognition from the Medal of Honor Society for the quality of the presentation and information. TMA C&CS staff offers ongoing assistance on a case-by-case basis to this unique group.

Customer Service

TMA C&CS staff members serve as the official points of contact for the TRICARE Executive Director to address requests for information and resolution of complicated TRICARE issues. In 2001, five TMA Customer Service and Beneficiary Education staff answered 11, 350 phone calls and 726 e-mail queries. The majority of these inquiries dealt with basic requests for information regarding the various TRICARE options. Due to availability of a vast amount of

- Overseas benefits;
- Timetables for implementation of new or expanded benefits;
- Communication about TRICARE changes;
- TRICARE Prime Remote for Active Duty Family Members;
- Next generation of TRICARE Managed Care Support Contracts;
- Health care quality;
- Performance measurements for TRICARE;
- Reserve benefits;
- Dual eligibility (TRICARE/Medicare);
- National Enrollment Database and CHCS II;
- Defense Eligibility and Enrollment System (DEERS) notifications;
- Changes in the dental benefit;
- Funding issues related to TRICARE for Life;
- Mental health benefits;
- Network development and retention of providers;
- Custodial care and case management;
- Primary Care Manager by Name Program; and,
- Debt collection and benefits advice.

Debt Collection Assistance Officer Program (DCAO)

In 2001, the TRICARE Office of Communication and Customer Service (TMA/C&CS) developed a comprehensive program to assist Service members and their families to resolve debt collection issues related to healthcare claims. "Team Customer Service" (a joint TMA and Service working group) stood-up a worldwide program in 30 days with flawless execution, synergy, and shared vision. TMA/C&CS aggressively marketed the program throughout the entire Military Health System to all 8.5 million eligible beneficiaries in record time.

From the TRICARE beneficiary's point of view, this top-notch customer service initiative assisted military families worldwide in getting their questions answered and problems solved. In many cases, years of billing issues are settled in 48 hours or less. Although this program operates at the TRICARE Management Activity (TMA) level as well as regionally, the data reported here is derived from the TMA Communication and Customer Service (C&CS) Office only. From July through December 2001, TMA C&CS handled over 3,100 active cases.

and processes have been implemented to address beneficiary perceptions and system deficiencies.

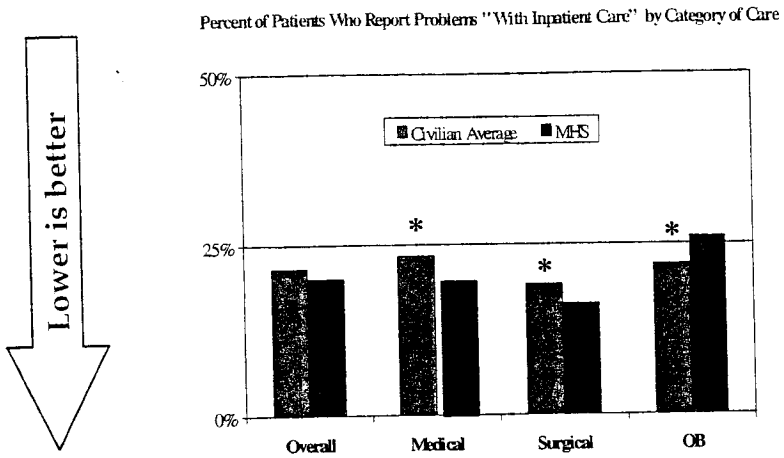


FIGURE 27 – Percent of Patients Who Report Problems with Inpatient Care By Category of Care

Communicating with Our Beneficiaries

During FY 2001, the TRICARE Office of Communications hosted 49 meetings with representatives of the Military Coalition and the Military and Veterans Alliance. Included in these meetings were biweekly meetings with the TRICARE for Life Working Level Panel and TMA program managers; quarterly meetings with the TRICARE for Life Senior Level Panel and the ASD (HA); and occasional meetings with the Coalition and Alliance Health Issues Team. In addition to discussions about TRICARE for Life and TRICARE Senior Pharmacy Program issues, the Office of Communications addressed many other provisions of the National Defense Authorization Act for 2001.

Partnership with the above groups resulted in early recognition of issues before they escalated to higher levels. The following is a sample of other topics discussed:

- Prime enrollment/disenrollment;
- Claims;
- Catastrophic cap reduction;
- Reimbursement for extended or new benefits;
- Customer service issues (who to call for help);
- Other health insurance;

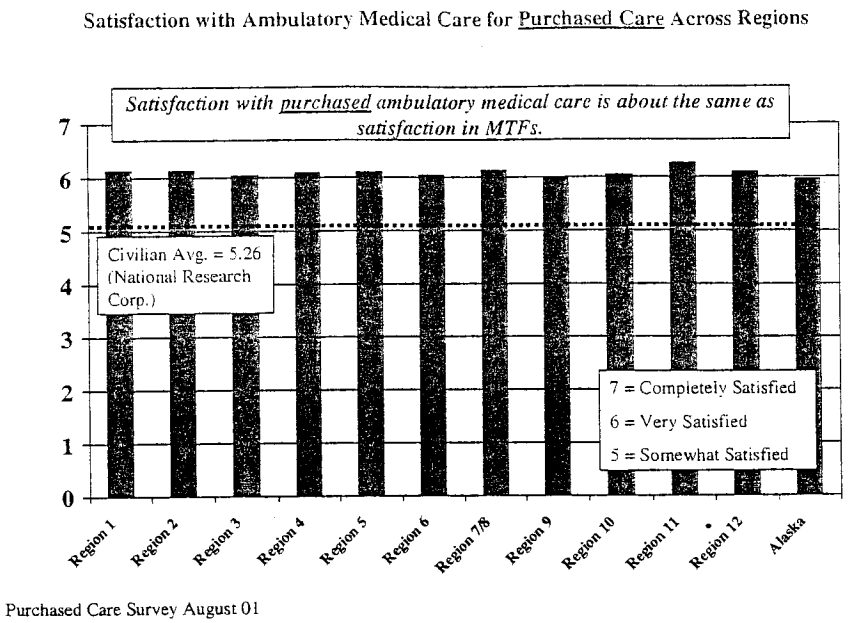


FIGURE 26 – Satisfaction with Purchased Ambulatory Care Across TRICARE Regions

Inpatient Care Survey (ICS)

The ICS is a survey of adult beneficiaries who have recently been hospitalized. The survey consists of two forms: 1) one form for those beneficiaries hospitalized for medical and surgical treatment and 2) one form for those beneficiaries hospitalized for childbirth. Respondents are asked about their experience and satisfaction with hospitalization from the time that they are admitted until after they are discharged. The ICS is designed by the Picker Institute, and permits comparisons to more than 500 civilian hospitals. Similar to the PCS, the ICS is also a recent initiative, and has been conducted on 22 sites. In FY 2002, the ICS will be expanded to a larger number of sites. This survey will be conducted on an annual basis.

ICS Results

Figure 27 presents the percent of patients who report "problems" with inpatient care. The data are presented by four categories of care: Overall, Medical, Surgical, and Obstetrics. The percentage of MHS beneficiaries who report problems with their care is consistently below the civilian average in every category of care but Obstetrics. Additional TMA resources are being directed to facilitate understanding of this issue in the Obstetrics population. The issues related to apparent dissatisfaction with some aspects of obstetrical care are being aggressively examined

and higher headquarters with valid and reliable information on access, quality of care, interpersonal relationships, and overall satisfaction.

PCS Figures and Results

Figures 25 and 26 display beneficiary satisfaction with ambulatory medical care in the purchased care setting over time and across MHS Regions. It is interesting to note that beneficiary satisfaction with purchased ambulatory medical care is very similar to beneficiary satisfaction with MTF care. As shown in Figure 25, on a seven-point scale, purchased care satisfaction scores range from 5.9 to 6.1 from June 2000 to August 2001. The civilian average is 5.26. The Regional view of purchased care satisfaction data shown in Figure 26 is consistently high and also about the same as satisfaction in MTFs.

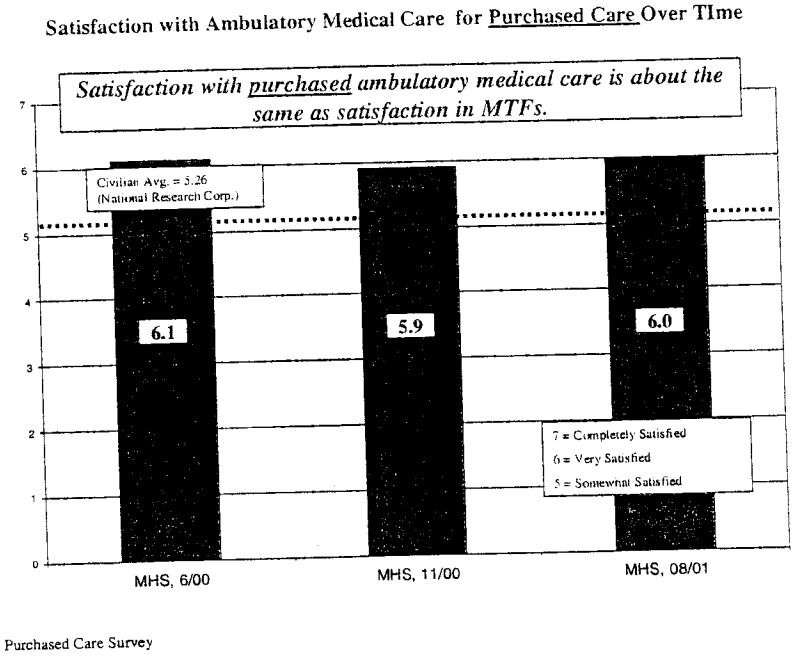


FIGURE 25 – Satisfaction with Ambulatory Medical Care for Purchased Care Over Time

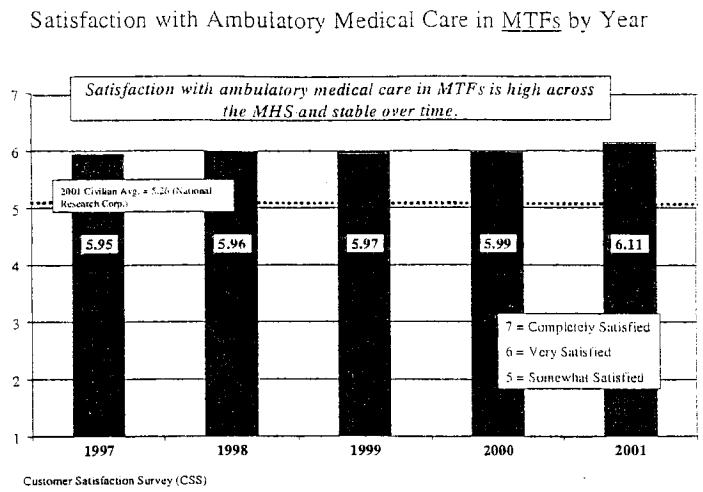


FIGURE 23 – Satisfaction with Ambulatory Medical Care in MTFs by Year

Figure 24 indicates the distribution of beneficiary responses when asked about their satisfaction with ambulatory care: most beneficiaries were either "very satisfied" or "completely satisfied" with the ambulatory medical care at the MTF.

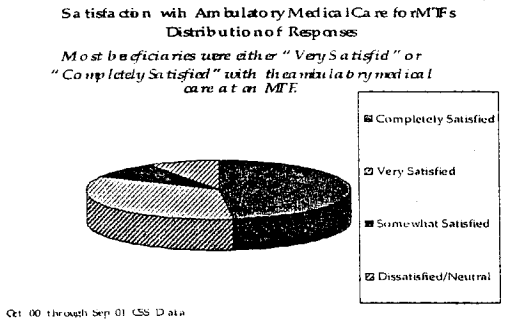


FIGURE 24 - Satisfaction with Ambulatory Medical Care Received at MTFs - Distribution of Responses

Purchased Care Survey (PCS)

The PCS is a recent survey initiative that is conducted quarterly as the purchased care counterpart to the direct care CSS survey. While the CSS measures beneficiary satisfaction with care at MTFs, the PCS' focus is on beneficiary satisfaction in the purchased care setting. The questionnaire used for the survey is adapted from the CSS. The PCS survey samples approximately 60,000 beneficiaries who have recently received care from civilian outpatient clinics. Similar to the CSS, the purpose of the survey is to provide DoD health care personnel

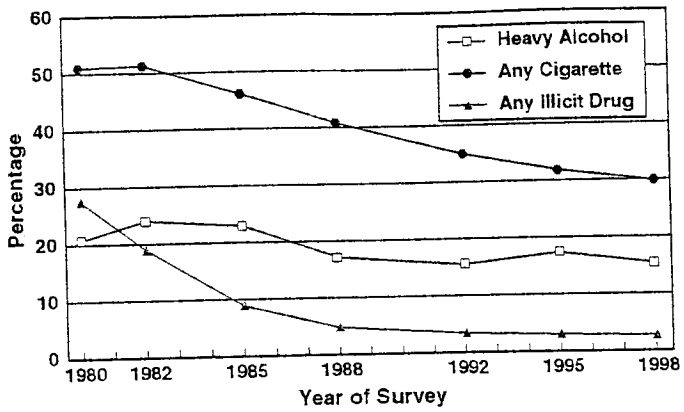


FIGURE 22 – Trends in Substance Use, Past 30 Days Total DoD 1980 - 1998

Customer Satisfaction Survey (CSS)

The CSS is a monthly survey of a random sample of approximately 50,000 beneficiaries who have recently received care from outpatient clinics operated by military treatment facilities (MTFs). The key determinants of satisfaction and the primary measures employed by the CSS are in the areas of Access, Quality and Interpersonal Relationships. Reports and analyses also focus on global measures such as overall satisfaction with medical care and overall satisfaction with clinics.

The questionnaire is short and focused, consisting of 17 multiple-choice questions. Both the scale and the questions were developed based on the Health Employer Data Information Set (HEDIS 3.0) National Committee on Quality Assurance (NCQA) Standards. Surveys are customized with the date, time and clinic and when possible, the provider's name. They are mailed directly to the patient's home 30-to-50 days after their outpatient visit. Approximate civilian benchmarks are available from the National Research Corporation (NRC).

CSS Figures and Results

The figures below indicate that satisfaction with ambulatory medical care in MTFs is high across the MHS and consistent over time. As shown in Figure 23, on a seven-point scale, the most recent average MHS score was 6.11, while the CY 2000 civilian average was 5.26. From 1997 through 2001, the CSS survey has shown that TRICARE beneficiary satisfaction with ambulatory medical care at MTFs is consistently higher than the civilian average of 5.26. This satisfaction rating is high across all of the MHS Regions.

Health Related Behavior Survey (HRBS)

The Health Related Behavior Survey is conducted every four years and measures various health behaviors among active duty personnel, including the use of illegal drugs, alcohol, tobacco, and at-risk sexual behavior assesses the mental health status of the force, and specific health concerns of military women. Additional topics include eating habits and gambling. The survey identifies important dysfunctional behaviors that can be targeted for intervention and treatment programs to provide better health care services to military personnel and their families.

Important goals:

- Describe how substance use and other health behaviors differ between demographic subgroups such as the age, pay grade and gender of service members.
- Examine trends in the use of illicit drugs, tobacco, alcohol, and selected other health practices and behaviors, as compared with previous DoD surveys;
- Examine military/civilian comparisons to compare findings of this survey and rates of illicit drug, alcohol and tobacco use in civilian populations reported in other national surveys; and,
- Identify demographic, psychosocial, and/or behavioral variables that are associated with or help to explain or predict substance use and other outcomes of interest among military personnel.

HRBS Figures and Results:

Figure 22 indicates an apparent downward trend and leveling off of drug use among active duty service members over the last 22 years. This has been accompanied by a downward trend in use of cigarettes, a leveling off of heavy alcohol use (defined as 5 or more drinks on same occasion 4 or more days of past 30 days).

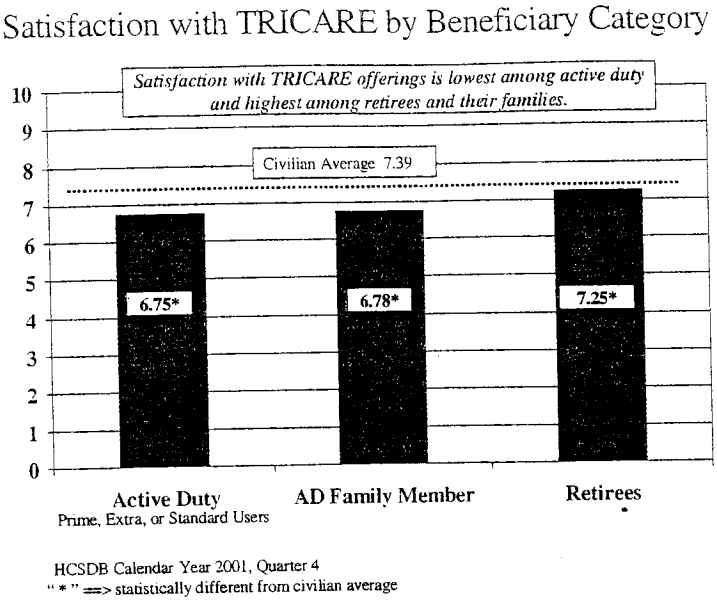


FIGURE 20 – Satisfaction with TRICARE by Beneficiary Category

In addition to monitoring beneficiary satisfaction with the TRICARE plan as a whole, the HCSDB also measures beneficiary ratings of providers, healthcare, and access to care. Ratings of providers, including personal doctors and specialists, and health care fall below civilian averages. As shown in Figure 21, on a ten-point scale, TRICARE MHS beneficiaries rate their provider as a 7.68 and rate their health care as 7.41, while the civilian averages are 8.23 and 8.04, respectively. The reasons for differences between TRICARE MHS ratings and civilian benchmark data are not revealed by the survey data and are the subject of scrutiny at this time.

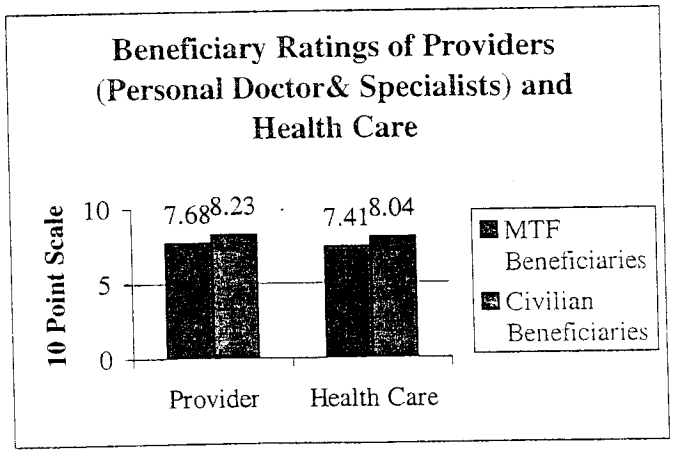


FIGURE 21 – Beneficiary Ratings (Prime, Extra/Standard) of Providers and Health Care; Difference in Responses of MHS beneficiaries compared with Civilian beneficiaries are statistically significant

Source – HSCDB Calendar Year 2001

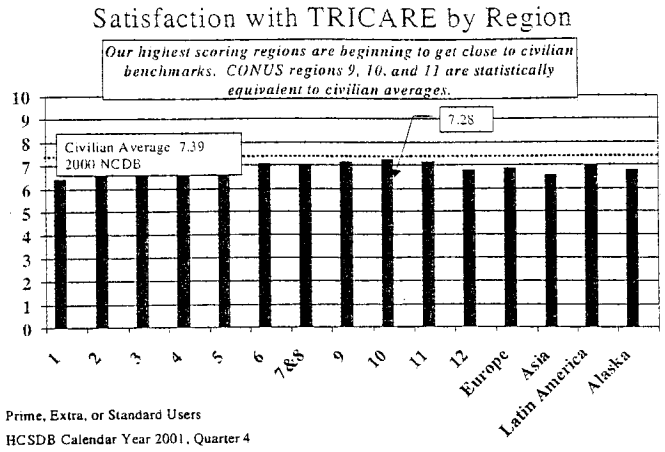


FIGURE 18 – Satisfaction with TRICARE by Region

When assessing satisfaction with TRICARE by enrollment status (i.e., type of healthcare plan), the HCSDB data indicates that TRICARE Prime beneficiaries are more satisfied with their care then TRICARE Extra/Standard beneficiaries. This is shown in Figure 19.

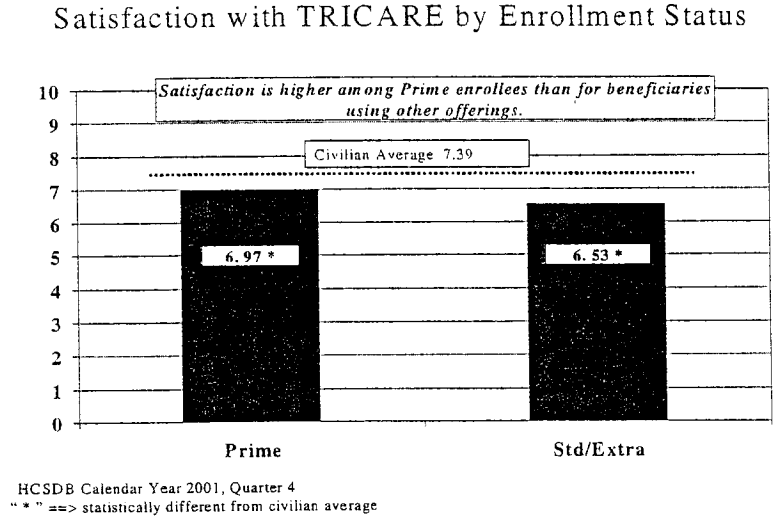


FIGURE 19 – Satisfaction with TRICARE by Enrollment Status

The final view of the satisfaction data, by beneficiary category, as portrayed in Figure 20, suggests that Retirees are more satisfied with their health plan than Active Duty members and Active Duty Dependents.

beyond that, by age, type of primary care manager, and catchment area. Beneficiaries can also compare TRICARE results to similar items in civilian health care from the National CAHPS Benchmark Database.

HCSDB Results

The following figures provide a window into the types of satisfaction indicators that are measured with the HCSDB. Satisfaction with TRICARE is assessed from a number of angles: over time, by Region, by Enrollment Status and by Beneficiary Category. Figure 17 portrays that satisfaction with TRICARE, as a health plan, is lower than the civilian average (7.39 on a scale of 1-10), but steadily increasing over time. Note that the difference between the TRICARE MHS satisfaction scores and the civilian average derived from the National CAHPS Database are statistically significant.

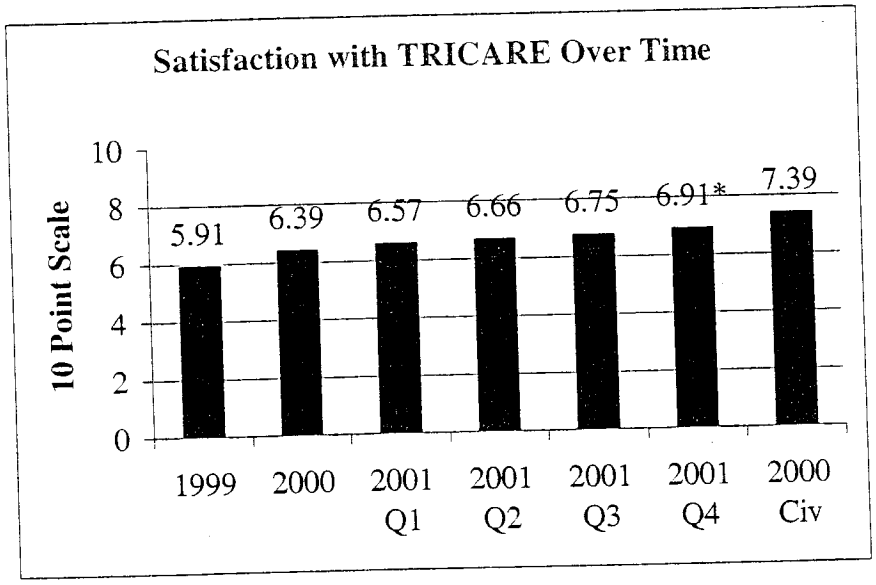


FIGURE 17 - Satisfaction with TRICARE over Time Prime, Extra, or Standard Users
* = Statistically different from civilian average

However, the Regional view of the data shown in Figure 18 demonstrates that the satisfaction scores among the highest scoring regions are similar to the civilian benchmark score of 7.39.

- Consist of a sample of *beneficiaries* such as – HCSDB, HRBS.

Event Based Surveys:

- Assess beneficiary experience with specific encounters, specifically customer service; and,
- Consists of a sample of *encounters* such as - CSS, PCS, and ICS.

Following is a brief description of the main MHS surveys:

The Health Care Survey of DoD Beneficiaries (HCSDB)

The HCSDB is a nonevent based quarterly survey of a complex probability sample of 200,000 beneficiaries per year over four quarters. The core of the survey is the Consumer Assessment of Health Plans (CAHPS) which is a mainstream survey instrument developed by a consortium of RAND, Harvard, and Research Triangle Institute (RTI). This survey tool is used by many civilian healthcare organizations, including the Centers for Medicare and Medicaid Services (CMS), thus permitting strong comparisons with civilian benchmarks. It consists of questions on the status of respondents' health, their need for health care, use of health care services, and experience with accessing health care from military and civilian sources. It comes in two forms: 1) an adult version (for those beneficiaries over the age of 17, and, 2) a child version (for adult sponsors of child beneficiaries). A special supplemental portion of the HCSDB provides the TRICARE MHS with the ability to focus specifically on issues of importance to the organization.

To enable comparisons between military and civilian health care, this survey has been designed to complement surveys used by commercial health plans, Medicare, state Medicaid programs, and other entities. To further facilitate military and civilian efforts to measure and improve quality in managed care, TMA will share survey data with the National Consumer Assessment of Health Plan Survey (CAHPS) Benchmark Database, which is administered by the Agency for Healthcare Research and Quality (AHRQ). CAPHS benchmarks currently provide civilian data that the MHS relies on to compare TRICARE to civilian healthcare plans.

Results of the HCSDB are posted in *The TRICARE Consumer Report* on the web at http://www.tricare.osd.mil/survey/hcsurvey/default. Examples of information available in this report include: data on the extent to which beneficiaries are satisfied with their care, have access to care, and use preventive care services. In addition, beneficiaries can take advantage of the website's interactive capacity to analyze results by enrollment group and beneficiary status, and

survey agendas change, the purpose of their content remains the same: to collect accurate information that health care leaders can use to improve health care for their beneficiaries. Following are examples of issues that TRICARE surveys regularly track.

Examples of Issues Monitored by TRICARE Surveys

- Source of Care: Where do beneficiaries get care?
- Preventive Services: Do military beneficiaries get the preventive services they should?
- Health Care Experience: Do beneficiaries experience problems getting care from military or civilian sources?
- *Health Plan Administration*: Are beneficiaries satisfied with administrative services, benefit information, and claims resolution?
- *Health Plan Confidence*: Are beneficiaries confident that TRICARE provides high care quality at a reasonable cost?
- *Health Status*: Are beneficiaries as healthy as their counterparts, as indicated by national age-adjusted figures?
- Demographic factors: What is the demographic composition of the beneficiary population, and what is the association between demographic factors and beneficiaries' evaluation of health care?

Source: TRICARE Management Activity. "TRICARE Management Activity Survey Program." March 2001

Major Health Care Surveys

TMA now conducts five major health care surveys:

- The Health Care Survey of DoD Beneficiaries (HCSDB);
- Health Related Behaviors Survey (HRBS);
- Customer Satisfaction Survey (CSS);
- Purchased Care Survey (PCS); and,
- Inpatient Care Survey (ICS).

These survey are categorized into two broad classifications:

Population Based Surveys:

- Assess a wider variety of issues such as needs for, access to, and use of preventive care, health status and insurance converge; and,

Beneficiaries' Perspectives on Quality of Care

Health Care Survey Activities FY 2001

The TRICARE Management Activity (TMA) actively evaluates the quality and performance of TRICARE healthcare services through various methods, including the administration of several health care surveys. These surveys supply information that helps focus quality oversight and improvement efforts. The TRICARE MHS health care surveys are designed to gather data on beneficiary satisfaction, utilization and needs on major health care issues and concerns. Regular surveys include those that provide comprehensive overviews of the experience and satisfaction with a range of care, while more focused surveys assess particular kinds of care. In addition to the routine surveys, TMA, from time to time, conducts special surveys on topical issues. Survey results are reported to TRICARE administrators, providers and beneficiaries. To provide a point of reference, civilian benchmarks are reported along side of the TRICARE MHS survey results when possible.

Background

Though the TRICARE MHS has demonstrated consistent interest in monitoring health care quality for its beneficiaries, until the mid-1990s, the use of surveys to assess health care was episodic. This changed in 1995 when Congress mandated that the DoD conduct annual surveys of beneficiaries eligible for military health benefits regarding their needs for, access to, and satisfaction with healthcare services. In response to the mandate, the Office of the Assistant Secretary of Defense (Health Affairs) instituted the Healthcare Survey of DoD Beneficiaries (HCSDB), which has been regularly conducted since that time. Other surveys have also been developed to provide data on particular aspects of the military health care.

Focus of Health Care Surveys

The agenda of the health care survey program is determined annually. As part of the annual budget setting process, a committee of TMA leaders and the TRICARE MHS Survey Workgroup assesses each survey in terms of its research objectives and value to the organization. Additionally, the agenda is shaped by frequent consultation with representatives from each of the Services during regular survey reviews. The focus of these reviews is to discuss methods that may improve the survey tools to make them more valuable in evaluating and improving the TRICARE program. During these reviews, discussions regarding the best manner in which to interpret the meaning of survey findings are also fundamental. While the TRICARE MHS

specialty group to track program progress with the criteria, data set selection and collection, and criteria validation and development.

The transition program is projected to run through March of 2004. Results will be reviewed, summarized, and final recommendations made with a view toward full implementation in 2004.

certification/oversight organization are being held. As currently planned the selected vender will, based on COE criteria and on a contractual basis, develop and field-test a COE certification process.

To date, 43 programs at Army, Navy, and Air Force medical centers are approved for COE program participation during the two-year transition. TMA is working closely with the DVA to encourage their participation. The DoD DVA Presidential Task Force endorses the COE program as an area for further DoD-VHA collaboration.

Why should these already busy programs choose to voluntarily participate in the COE transition program? There are at least two reasons.

- The COE transition program's validation of clinical quality criteria is a necessary prerequisite to the development of a COE certification process within DoD. Such a certification process will allow us to communicate our clinical excellence to our beneficiaries and other significant stakeholders. We are often in direct competition with our civilian peers for resources (patients, trainees, and research). The transition program represents the first system-wide use of clinical quality criteria for COEs. It will help provide the evidence we need to be able to demonstrate to our beneficiaries, referring clinicians in our surrounding communities, and other stakeholders that we provide truly first rate care.
- The ongoing refinement of clinical practice criteria. Leap Frog and other quality improvement initiatives in the civilian market are developing criteria that may ultimately restrict certain care (e.g., cardiovascular surgery) to high volume centers, threatening the existence of lower volume military health care programs and Graduate Medical Education. We need to be able demonstrate that we provide care that is equal to or better than these civilian centers. To do that, we need data and evidence that substantiates the quality of our care. The transition program is designed to provide that.

The National Defense Appropriations Bill for Fiscal Year 2002 contained a provision allocating $1.5 million to design, test, and evaluate models for expanding health care Centers of Excellence. The COE transition program has a contract with the Uniformed Services University of the Health Sciences (USUHS) to provide modeling support for criteria validation and development. The USUHS group will work closely with clinical panels from each COE

- Cranial and spinal care;
- Gynecologic oncology;
- Liquid organ transplantation (e.g., bone marrow);
- Major head and neck oncology;
- Neonatal-perinatal medicine;
- Solid organ transplantation (e.g. kidney); and,
- Total joint replacement.

The Healthcare Quality Initiatives Review Panel (HQIRP) supported and funded these efforts. HQIRP envisioned that the project management team would work with a currently recognized, national, healthcare-accrediting organization to develop a COE certification program. Such an organization, working with the TRICARE MHS, would be responsible for the certification of candidate facilities and for the development and implementation of an assessment process created in collaboration with the TRICARE MHS. HQIRP also envisioned that the COE program would eventually be extended to include civilian programs throughout the country.

A follow on working group, the COE Integrated Project Team (IPT) is composed of senior health policy experts from the Services, Department of Veterans Affairs (DVA), Office of the ASD (HA), and TRICARE Management Activity (TMA). During the development of a COE implementation plan, the IPT recognized that the non-validated criteria presented problems for most military programs. The use of certain "critical" criteria (i.e., compliance essential for COE participation) meant that few military programs would even be eligible for designation. In particular, the required volume of patients (often correlated with clinical outcomes and as a surrogate for clinical quality) exceeded that achieved by military programs (which tend to be smaller than their civilian counterparts). Therefore, the first two years of the program will focus on the validation and modification of these criteria as well as the use outcome data and external benchmarking; and, none of the criteria will be considered critical during the transition phase. During the transition phase, participation will be limited to military and DVA facilities. Transition phase applications are being accepted for participation in the transition phase. Additional specialties are also being considered.

Credible, independent external certification is considered highly desirable. This is particularly true as TRICARE COE looks to expansion beyond the transition period to inclusion of an increasing number of civilian programs. Discussions with an appropriate

The measures reported by PHOTO are intended to enable evaluation of both effectiveness of interventions (clinical effectiveness) and the effectiveness of the system implementation of evidence-based practice (implementation). Strategic benefits accrue because the TRICARE MHS is able to use the standard metrics reported by PHOTO to apply a common and agreed upon assessment of organizational performance across all elements of the TRICARE MHS. Operational benefits accrue because performance measures reported at the local level are designed to assess the health of the population, the quality and cost effectiveness of the delivery system, and the impact of clinic practice on the individuals treated. Measures selected reflect performance targets that are meaningful to the customer and provider, and which can be used directly to improve performance. Clinical measures may be health outcomes, impact measures, or process measures. With the focus on optimization, PHOTO provides a substantive level of feedback for reporting performance of treatment facilities. This allows managers to key in on potential problem areas, and to increase levels of access, optimize utilization of resources within the treatment facility, thereby minimize the cost of health care. Selected PHOTO measures will be portrayed in next year's report to Congress.

TRICARE Centers of Excellence

The revised TRICARE Centers of Excellence (COE) program began on April 1, 2002. The COE program represents the Department's first system-wide use of clinical criteria to identify and improve the quality of health care in certain high risk, high technology specialties. The first two years represent a transition from the current Specialized Treatment Service (STS) and related COE programs to the new clinical criteria-based COE program. Objectives for the two-year transition program include validation of the initial proposed criteria and development of an external certification process.

Two workshops of Tri-Service DoD and civilian expert panels in CY 2000 produced broad, literature-based, expert-reviewed standardized measures for the assessment, certification, designation, and monitoring of 10 COE specialty areas. However, this process did not include or plan for external validation of the criteria established by the panels. The specialty areas included:

- Burns;
- Cardiac surgery;
- Complex general surgery;

local levels to evaluate the quality of their data, as well as their contribution to total plan performance.

The strategic objective for PHOTO is to provide feedback to TRICARE MHS providers, managers and stakeholders about the progress and effectiveness of the business process reengineering efforts with actionable data. Implementation guidance for reengineering efforts recognizes that use of a set of TRICARE MHS-wide standardized metrics is key to the ability to measure performance, motivate and drive change, and communicate to TRICARE MHS stakeholders. Metrics are linked to critical components of the TRICARE MHS vision and must be available for review and comparison at all levels of the TRICARE MHS in order to support achieving that vision. The TriService Metrics Workgroup determines which specific comparable metrics will allow all components of the TRICARE MHS to report progress toward optimization goals. Where applicable, the Health Employer Data Information Set (HEDIS®) based metrics mirror performance and quality measures used throughout the healthcare industry. PHOTO provides insight into TRICARE MHS business practices with the ability to drill down to a level of granularity detailed enough to allow business decision makers at all levels of the TRICARE MHS to use the information to effect change at their level.

The initial release of twelve metrics, contained in Appendix E, in September 2001 provides information about customer satisfaction and broad measures of clinical and business activity, such as admission and visit rates per 1,000 enrollees; completeness of workload reporting and rates for potentially preventable admissions. The database that supports the metrics is refreshed monthly. PHOTO communicates TRICARE MHS performance information at all levels of command. Since performance metrics are standardized and can be viewed at several levels of aggregation, from MTFs up through the Services and TRICARE regional levels. Services can use PHOTO for MTF profiling. Future enhancements to PHOTO will allow for reporting of clinical data at the level of individual Primary Care Managers.

The benefits of PHOTO derive from its support of managers and commanders who use PHOTO to evaluate performance at their level in the TRICARE MHS, and the activities associated with optimization, and then take action to improve performance of their own elements of the MHS organization. These benefits are both strategic and operational because TRICARE MHS performance is continually monitored at all organization levels, including at the PCM level, and the TRICARE MHS moves more fully into Population Health Management.

manage extraordinary conditions. Over the 32 months that the ICMP-PEC was available, several beneficiaries experienced marked improvement in their medical condition due to carefully planned care coordination and case management. Some of these individuals no longer require the level of skilled nursing care and services that were offered through ICMP-PEC program.

Through individualized case management, the ICMP-PEC was specifically designed to provide a bridge for custodial care patients between acute and extended care services. It was also designed to improve the quality of care, control costs, and support patients and families through catastrophic medical events. The lessons learned by the Department through the ICMP-PEC will serve as a foundation for future benefit changes and enhancements to better serve this unique population.

Population Health Operational Tracking and Optimization (PHOTO)

The Executive Information/Decision Support (EI/DX) Program Office for the Military Health System (MHS) provides decision support information and tools used by managers, clinicians, and analysts to manage the business of healthcare within the MHS. To enable the flow of complete and accurate information to the decision-makers, EI/DS manages the receipt, processing, and storage of tremendous volumes of data that characterize operations and performance. The data, which include beneficiary, provider, financial and healthcare use information, are processed within a centralized data repository to improve data quality, integrated and then made available to users through a variety of projects and specialized data marts developed to meet business requirements at the MHS level.

Population Health Operational Tracking and Optimization (PHOTO) provides, in a single application, a concise set of health plan performance measures to give healthcare executives and managers information regarding the effectiveness and efficiency of their program execution as well as a friendly and easy to use browser interface ensuring fast and reliable access.

PHOTO enables visibility via the web browser interface into TRICARE Prime beneficiary healthcare patterns for decision-making purposes. Personnel at all levels of the TRICARE MHS can access standardized metrics to measure the performance, outcomes, satisfaction, and cost effectiveness of the healthcare system. The metrics incorporate business, clinical, customer satisfaction, population, and resource data from all facets of the healthcare delivery system while multiple levels of aggregation allow managers at corporate, regional, and

March 1999. Established as a waiver program, it provided coverage for care and services that were normally restricted from coverage under the TRICARE basic benefit. Specifically, for a beneficiary who met the TRICARE custodial care definition, the limitations of coverage under the basic benefit were one hour of skilled nursing care per day, twelve physicians visits per year related to the custodial condition, durable medical equipment and medications. The Department recognized that this exclusion of coverage, when a family member is deemed to be a custodial care patient, is both a financial and emotional burden on the family caregiver. Consequently, the Department used the ICMP-PEC authority to cover medically necessary care for these patients and to enable TRICARE case managers to help maximize available resources for military and retiree families.

TRICARE regulations defined custodial care in terms of the ICMP-PEC as "care rendered to a patient who:

- Requires care for a mental or physical disability which is expected to continue and be prolonged;
- Requires a protected, monitored, or controlled environment whether in an institution or in the home;
- Requires assistance to support the essentials of daily living; and,
- Is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment."

The ICMP-PEC program provided for medically necessary skilled nursing care. Diagnoses treated through this program ranged from Amyotrophic Lateral Sclerosis (ALS) to Quadriplegia. By working collaboratively with skilled medical professionals, family members usually learned to safely and effectively provide activities of daily living (ADLs) and some care to the family member. Qualified case managers also often helped the family arrange for some assistance for additional support through community-based resources.

Participation in the ICMP-PEC required periodic reassessment of the patient's medical condition; reassessments are an essential aspect of effective case management. Integral to effective case management, the case manager updated the individualized plan of care that identified appropriate resources to meet the individual patient's medical needs with each reassessment performed. This helped organize the multidisciplinary services often required to

its mission by identifying opportunities for improved performance which can be pursued either by TMA/HPA&E or by other organizational entities in the MHS with a stake in the issue.

The TOPS Reports were developed by HPA&E and were first published in June of 1998. The metrics set is evolving as TMA strives to continuously improve on the monitoring and evaluation of the performance of the MHS. Any modifications to TOPS are subject to the approval of the Tri-Service Metrics Work Group. To reflect the different functions of the MHS, the TOPS health care metrics are organized by various perspectives. This is helpful to focus attention on the function that is being measured. It defines the population of interest and ensures that none of these functions are minimized. The TOPS reports are divided into the following perspectives:

- Employer Perspective focuses on the MHS as an employer;
- Health Plan perspective focuses on how well TRICARE is performing as a Health Plan, specifically on its ability to meet the needs of TRICARE Prime enrollees;
- MTF Perspective is the view of the organization that provides the care in the MTFs, with particular emphasis on cost, quality, and access;
- Dental Treatment Facility (DTF) Perspective captures the satisfaction of beneficiaries receiving care from the military DTFs (reported in section on dental quality performance); and,
- Data Quality Perspective is designed to assess the completeness, timeliness, and quality of MHS data.

Some of the TOPS measures are derived from objective information such as medical records or medical databases. Other TOPS measures are derived from surveys or self-reports. Selected TOPS measures derived from surveys and self-reports are presented in the Beneficiary Satisfaction with Dental Care section of this report.

Individual Case Management Program for People with Extraordinary Conditions (ICMP-PEC)

Under the provisions of Section 704 of the FY NDAA for 1993 [Pub. L. 102-484.], Congress enacted 10 U.S.C. 1079(a)(17) which allowed the DoD to establish the Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC). This allowed a reasonable expansion in patient care for patients who had exceptionally serious, long-range, costly and incapacitating conditions. The Department officially implemented ICMP-PEC in

However, the problems of data management identified in this project will serve the Department well as it moves forward in its attempts to perform HEDIS®quality measurement across the broader TRICARE MHS. Furthermore, the implementation of the Composite Health Care System, Version II (CHCS II) computerized medical record with its robust data repository functions has the potential to dramatically improve data quality management.

DoD Facility Report Cards

A Health Affairs Policy Memorandum of February 3, 1998 directed all military hospitals and clinics to display a facility specific 'report card' in a conspicuous location at the facility. The Services are compliant with this directive and some facilities have posted the report cards on their MTF websites. The purpose of the report card is to enhance facility communication with its consumers about the facility's performance regarding at a minimum:

- Waiting times in days for appointments for major services such as Primary Care, OB-GYN, Pediatrics, Orthopedics, Mental Health, or Pharmacy;
- Patient satisfaction results from the DoD Customer Satisfaction Survey;
- The summary grid score from the most recent JCAHO survey with an explanation of the purpose of the JCAHO and the relevance of the summary grid score; and,
- Grid scores from the most recent JCAHO survey in the areas of Credentialing, Assessing Competence, Infection Control, and Nursing with an explanation of the grid element.

TRICARE Operational Performance Statement (TOPS) – Objective Measures

The TRICARE MHS Operational Performance Statement (TOPS) is an internal management tool that provides the leadership and staff of the TRICARE Management Activity (TMA) and the Assistant Secretary of Defense/Health Affairs (ASD/HA) with a quarterly snapshot of the performance of the Military Health System (MHS). The metrics contained in TOPS focus both on long-term strategic goals and near term operational objectives. TOPS serves as both a statement and as an evaluation tool. As a statement, it establishes a historical record of performance that can be used to determine long-term trends in performance. As an evaluation tool, it is a compendium of routine analyses conducted by the TMA's Office of Health Program Analysis and Evaluation (HPA&E) in its surveillance of the TMA MHS. TOPS fulfills

in 2001 and therefore could not be compared across measurement years. As portrayed below, the control rate was closer to the NCQA 2001 average than the screening rate.

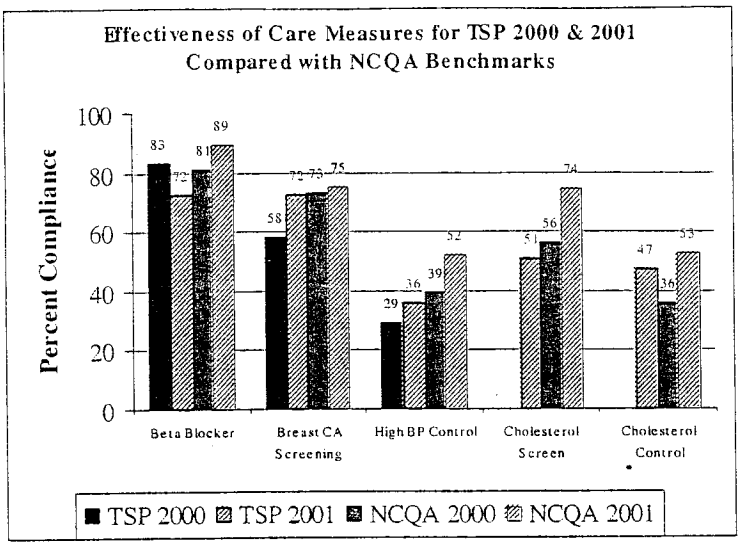


FIGURE 16 – Effectiveness of Care Measures

Access to Preventive/Ambulatory Health Services

This measure defines access as those members who were continuously enrolled during the measurement year and had at least one ambulatory or preventive-care visit. As shown in Table 27, the vast majority (over 95 percent) of all TSP members in the study continued to experience a high degree of access to preventive/ambulatory services for HEDIS® 2001.

Table 27 - Access to Preventive/Ambulatory Health Services

Data Elements	HEDIS ®2000 Age 65+	HEDIS® 2001 Age 65+
Denominator (same as eligible member population, i.e., members who met all denominator criteria)	20,503	27,531
Numerator events by administrative data	19,869	26,377
Reported rate	96.91%	95.81%**

** $P < 0.01$

Overall, the TSP HEDIS® experience validated data quality concerns, which are being addressed vigorously by the TRICARE MHS.

The clinical quality measure results of this demonstration project are difficult to interpret. Small sample size, unavailability of medical records, coding changes in the HEDIS® 2000 data set, and the brief duration of the project all affected data quality management and validity.

- Practitioner Data - *Not compliant.* MTF provider data maintained at the local MTF level and could be sent to Service level databases but not to a central site for HEDIS® purposes. Impact - Increased cost of using Hybrid methodology to collect measures requiring practitioner data (e.g., Controlling High Blood Pressure) or inability to report some measures (e.g., Follow-Up After Hospitalization for Mental Illness, Board Certification/Residency Completion, Availability of Language Interpretation Services).
- Data Integration - *Substantially compliant.* The MHS did not have a reliable method for integrating ancillary data (lab, pharmacy, and radiology). Impact - Inability to report measures requiring administrative ancillary information (e.g., Antidepressant Medication Management, Outpatient Drug Utilization).

Vector Research, Incorporated (VRI), prepared the regional reports regarding the HEDIS® measures used in the TSP Program. A number of confounding variables and bias encountered by VRI included:

- Small sample sizes which skewed the data for some measures;
- Changed technical specifications between HEDIS® 2000 and HEDIS® 2001 which encumbered comparisons of year to year rates; and,
- Limitations in military information systems that constrained some data collection.

Effectiveness of Care Measures

Because of the limited scope and brief duration of this project, mature data providing a view over several years of time could not be developed. The limitations previously discussed relating to information systems capabilities, practitioner data and medical record availability further influenced the quality of data. Below are portrayed some representative data reflective of the HEDIS® measures which were studied. As shown in Figure 16 the percentage of TSP members in the studies who received breast cancer screening and whose high blood pressure was under control increased while the percentage receiving Beta-Blocker treatment after a heart attack decreased from 2000 to 2001. While none of these aggregate rates reached the HEDIS® 2001 averages, the percentage of TSP members receiving breast cancer screening came very close to the HEDIS® benchmark, Cholesterol management data was collected for the first time

Integral to HEDIS® is the requirement that 'members' of a plan are enrolled in that plan for a year prior to measurement of data. Hence, HEDIS® 2000 and 2001 were the instruments that drove the data collection effort.

HEDIS® provided specifications for the development of Hybrid and Administrative measures. The Hybrid methodology refers to the use of medical record data and was permitted for certain, but not all, measures. The Administrative methodology refers to the use of automated databases and/or information systems for measure development.

Based on HEDIS® specifications, the target sample size for each Hybrid measure was 411 patient records per Region. An over-sampling of 15 percent was used to allow for exclusions. If fewer than 411 enrollees within a Region met the eligibility criteria for a measure, records from all eligible enrollees were included in the sample. Clinical records were abstracted at the MTFs by certified, contracted abstractors.

The CMS required an external audit of Medicare HEDIS® 2001 production to ensure reliability and validity of results. PricewaterhouseCoopers, a licensed vendor of the National Committee on Quality Assurance (NCQA), the agency that maintains the HEDIS® criteria set, conducted a full audit of TSP HEDIS® in accordance with NCQA requirements. The auditors concluded that all the TSP reported HEDIS® 2001 measures conformed to specifications. Information systems (IS) capabilities were rated "not compliant," "substantially compliant," or "fully compliant." IS ratings, key discrepancies noted by the auditors, and the impact of these discrepancies are summarized below:

- Coding - *Substantially compliant.* MTFs did not capture and/or use some codes or used non-standard codes. Impact - inability to report some HEDIS® measures (e.g., Inpatient Utilization – Nonacute Care).
- Medical Data - *Substantially compliant.* There was lack of availability of some medical records at the MTFs or records from network providers were not available. Impact - the auditors were unable to determine if this had an impact on HEDIS® results.
- Membership Data - *Fully compliant.* The Iowa Foundation for Medical Care held the contract responsible for TSP membership. Impact - appropriate processing, maintenance, and control of enrollment files facilitated HEDIS® measure production.

TRICARE Senior Prime Demonstration Program

The Balanced Budget Act of 1997, Public Law 105-33, authorized a Medicare Subvention Program for Military Retirees eligible for Medicare. Under the terms of this demonstration program, retirees eligible for benefits from both Medicare and the Military Health Services could choose to enroll a DoD-operated managed care plan, called TRICARE Senior Prime (TSP) that also met the requirements of a Medicare Health Maintenance Organization (MCO). This bold initiative began services at six DoD sites in January 1999 and continued services through December 2001, overlapping the TRICARE for Life Program that started in October 2001.

As of January 1997, the Health Care Financing Administration, now known as the Center for Medicare and Medicaid Services (CMS), required MCOs to report on performance measures from the Health Plan Employer Data and Information Set (HEDIS®) relevant to the Medicare managed care population. The HEDIS® set of standardized performance measures is designed for purchasers and consumers to compare the performance of health plans. The measures include significant public health issues as well as consumers' experience with the health plan customer service, access, and claims processing. Therefore, fourteen HEDIS® measures were selected for the TSP Demonstration Program as shown in Table 26.

TABLE 26 - HEDIS® 2001 Measures Reported for TSP Plan Performance

Hybrid Method (Derived from Medical Record Data)
Beta Blocker Treatment After a Heart Attack
Breast Cancer Screening
Controlling High Blood Pressure
Cholesterol Management After Acute Cardiovascular Events
Administrative Method (Derived from Automated Databases)
Adults' Access to Preventive/Ambulatory Health Services
Frequency of Selected Procedures
Inpatient Utilization – General Hospitalization/Acute Care
Ambulatory Care
Mental Health Utilization – Inpatient Discharges and Average Length of Stay (ALOS)
Mental Health Utilization – Percentage of Members Receiving Inpatient, Day/Night, and Ambulatory Services
Chemical Dependency Utilization – Inpatient Discharges and ALOS
Chemical Dependency Utilization – Percentage of Members Receiving Inpatient, Day/Night, and Ambulatory Services
Chemical Dependency Utilization – Percentage of Members Receiving Inpatient, Day/Night, and Ambulatory Services
Total Enrollment by Percentage
Enrollment by Product Line

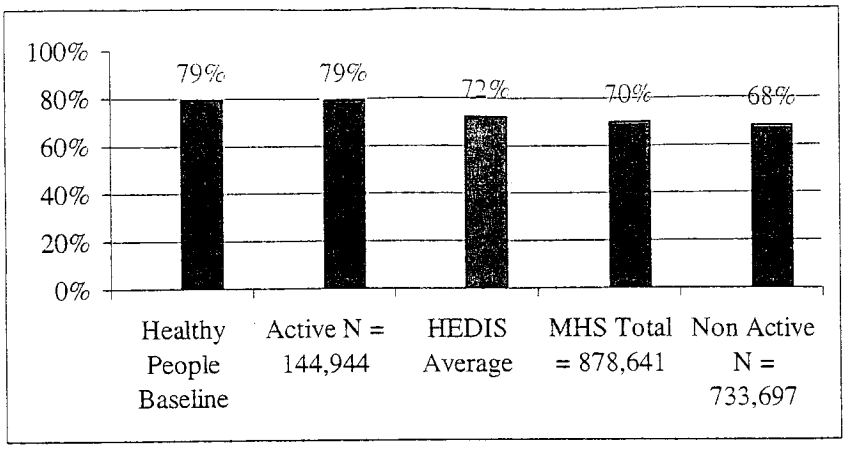


FIGURE 14 - Rates of Cervical Cancer Screening MTF Enrollees/HEDIS® 2000-2001

Breast Cancer

Breast cancer is the second most common type of cancer among women in the United States. More than 180,000 women are diagnosed with breast cancer every year. A screening mammogram is the best tool available for finding breast cancer early before symptoms appear. As with pap smears for cervical cancer, mammograms reduce the risk of dying from breast cancer through early detection. Screening mammograms are the indicator used as part of the preventive services clinical practice guideline noted above. As a baseline for the implementation of that guideline, the SAP directed a study to determine the current rate of mammography screening for women enrolled in the direct care system. The study data showed an overall MHS rate of 70 percent, which compares favorable with the HEDIS® 50th percentile of 73 percent and the Healthy People 2010 goal of 70 percent. Figure 15 shows these data graphically.

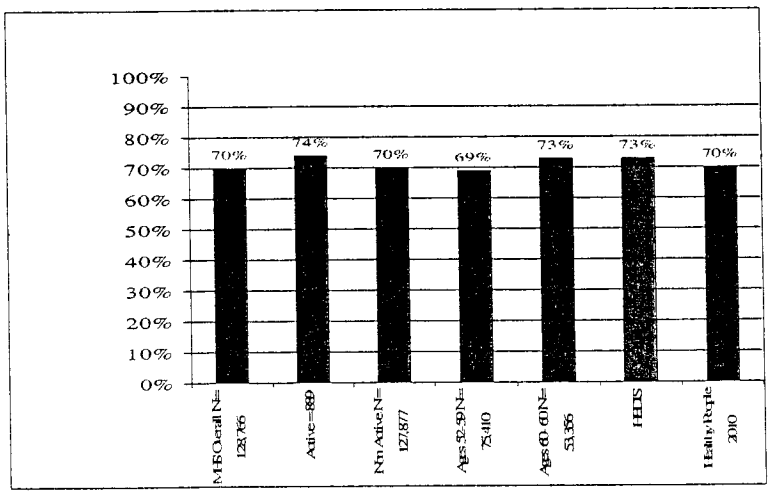


FIGURE 15 - Rates of Breast Cancer Screening Among MTF Enrollees/ HEDIS® & Healthy People 2010 Goals

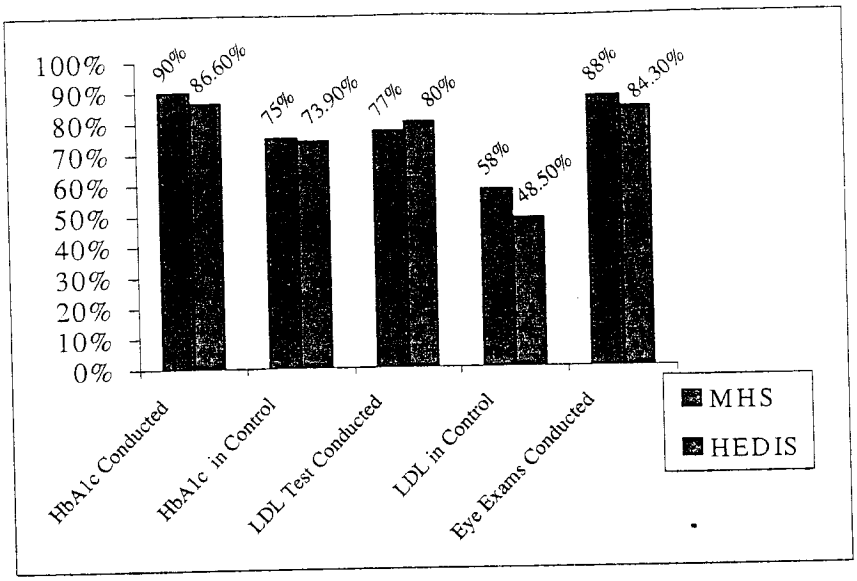


FIGURE 13 – Diabetes Test Compliance & Control MTF Enrollees/HEDIS®; N=37,187

Clinical Preventive Services

Cervical Cancer

Cancer of the cervix is the sixth most common cancer in women in the United States. In 1998, there were an estimated 14,500 new cases of invasive carcinoma of the cervix, over 50,000 cases of carcinoma in situ, and 4,800 deaths from the disease. The clinical stage of the disease at the time of presentation is the most important determinant of subsequent survival. Therefore, the widespread use of the screening test developed by Dr. Papincolaou, known as the 'pap' smear, has effectively reduced mortality. In anticipation of the release of the DoD/VA clinical practice guideline for preventive services, the TMA Scientific Advisory Panel directed the study of cervical cancer screening. The rate of Pap smear screening for 878,601 women in enrolled in the direct care component of the MHS was 70 percent overall, 79 percent for active duty and 68 percent for non-active duty women. Active duty women are required to have a pap smear annually. The recommendation for non-active duty women is from one to three years. Figure 14 displays these rates in comparison with the HEDIS® 50th percentile.

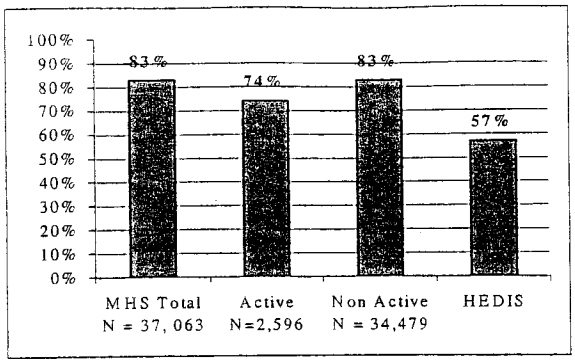


FIGURE 12 - Comparison of Rate of Appropriate Utilization of Asthma Medications:
MTF Enrollees/HEDIS® 2000-2001

Diabetes

DoD and VA developed a clinical practice guideline for diabetes because of the:

- Prevalence of diabetes in the DoD and VA populations;
- Costs associated with complications;
- Association with comorbid conditions, and,
- Preventable morbidity and mortality.

Three of the measures that indicate effectiveness of primary control of diabetes are:

- Measurement of the glycosolated hemoglobin (HbA1c), a blood test that assesses the degree of control retrospectively over a two to three month period [Healthy People 2010 goal is 50 percent of those with diabetes];
- Measurement of the low density lipoprotein cholesterol values which are associated with cardiovascular disease;
- Examination of the retina for retinopathy, an indicator of microcirculation changes in patients with diabetes (the leading cause of blindness in the United States is due to diabetes) [Healthy People 2010 goal is 75 percent].

Figure 13 shows that the TRICARE MHS outcomes exceed the HEDIS® 90th percentile and the Healthy People 2010 goals in all areas except for Lipid testing [the MHS was within 2.8 percent of the HEDIS® 90th percentile]. These results are encouraging as a baseline for population health improvement in addressing the health care needs of patients with diabetes.

- Improve the effectiveness and efficiency of the health care delivery process; and,
- Support the practice of evidence-based health care through the application of clinical practice pathways.

Having covered the ORYX® initiative earlier in this report, the content below relates to the Special Studies under the NQMP. The FY 2001 studies focused on asthma care, diabetes care, and the clinical preventive service areas of breast and cervical cancer screening.

Asthma

Asthma care is one of the DoD/VA clinical practice guidelines. DoD and VA selected asthma because of the

- Prevalence of asthma in both the DoD and VA populations;
- Health risks associated with asthma; and, the
- Mitigating effects of early diagnosis and preventive treatment on the frequency and severity of asthma symptoms and mortality.

The Health Plan Employer Data and Information Set (HEDIS®) measures asthma in relation to the use of appropriate medications by members with persistent asthma. HEDIS® reports its results in terms of percentiles, which refers to the proportion of health plans that are reporting at that rate of compliance with the HEDIS® standard. Figure 12 shows the initial measurement of appropriate use of asthma medications for the MHS compared with the HEDIS® 50th percentile for health plans. What this means is that one half of the health plans participating in HEDIS® report a 57 percent rate of appropriate use of asthma medications. The 90th percentile for HEDIS® health plans for appropriate use of asthma medication was 68 percent. Thus, the TRICARE MHS performs substantially better than 90 percent of the HEDIS® participants regarding this indicator. A follow-on study is planned to focus on the ratio of corticosteroid (preventors) to bronchodilators (relievers) and a severity measure assigned to each patient visit as well as more delineated prevalence information on emergency room use and admission data.

Although the Post-Deployment Guideline is the only guideline implemented DoD-wide as directed by the Assistant Secretary of Defense for Health Affairs, the next section of this report describes two of the CPGs selected for study by the National Quality Management Program. The Army has vigorously pursued additional tool kit-supported guidelines for primary care clinics at all AMEDD MTFs for Low Back Pain (Feb FY00), Asthma (Sept, FY00), Diabetes (January, FY01) and Tobacco Use Cessation (Sept FY01).

Metric measurement has been identified as being key to guideline implementation. CPG-based measurement is important to obtain provider interest in guideline implementation, to provide feedback to clinics and primary care managers implementing the guidelines and for benchmarking purposes. The DoD is in the process of developing methods for electronic measurement of clinical practice guideline-based metrics under a number of various TMA-level initiatives: the National Quality Management Program Special Studies, Population Health Operational Tracking and Optimization program (PHOTO) and Service-level strategies.

The National Quality Management Program – Special Studies

The National Quality Management Program (NQMP) is a TRICARE MHS program focusing on the direct care system of military hospitals and clinics and is specifically designed to measure clinical outcomes and process improvement. It accomplishes this by providing governance of the JCAHO ORYX® process and the performance of special studies in focused areas. The goals of the NQMP enable the TRICARE MHS to:

- Participate in the JCAHO ORYX® performance metrics process by submitting MTF data to JCAHO (as described earlier in this report in the Foundation Section);
- Perform clinical studies directed by the Scientific Advisory Panel of the TRICARE Clinical Quality Forum;
- Compare MHS outcomes with civilian clinical benchmarks;
- Perform internal comparisons within the TRICARE MHS;
- Identify 'best clinical practices'; and,
- Facilitate performance improvement.

The Scientific Advisory Panel (SAP) is the advisory group for the NQMP special studies. The SAP plans, develops, and directs clinical studies in support of the MHS performance improvement efforts. The goals of the SAP are to:

- Improve the health status of the population we serve;

guidelines within the AMEDD from FY98 through FY01. The AMEDD/RAND Project focused on:

- Development of a process to implement CPGs;
- Piloting of that implementation process within three AMEDD regions; and,
- Evaluating the impact of that CPG implementation process by comparing condition-specific quality, cost and access outcomes at pilot and non-pilot military treatment facilities (MTFs) within the AMEDD.

From its work with RAND, the Army has developed its current plan for implementation of DoD/VA CPGs within primary care whose steps are to:

- Develop provider and patient tools with incorporation into a CPG specific tool-kit;
- Pilot CPG tool kits to ensure CPG tool utility;
- Introduce tool-kits at 6 month intervals into MTF primary care portals via an educational satellite broadcast modeling;
- Implement CPGs to MTF clinic teams; and,
- Measure CPG metrics for process improvement and internal and external benchmarking purposes.

CPG tool kits are seen as essential to guideline implementation. CPG tools kits incorporate lessons learned from the AMEDD/RAND pilot, the Cochran Collaboration, the Institute for Healthcare Improvement, the Robert Wood Johnson Foundation, the Institute for Clinical Systems Improvement and the guideline implementation literature. AMEDD CPG tool kit development includes bringing together focus groups of Tri-Service and VA providers to develop provider support, patient self-management support, system/system process support and automated disease management informatics system/process tools. Provider support tools include documentation tools to streamline and standardize clinician documentation, continuing medical education videos, and provider reminder cards. Patient self-management tools include patient self-care brochures, videos, and CD-ROMs. Process/system support tools include guideline metric measurement and feedback loops, corporate "best-buy" pharmaceutical and medical logistics items, and incorporation of CPGs into CHCS II. The Army continues to lead the tool kit development effort with the VA supporting development of provider pocket guides, key point and guideline summary reminders. AF, Navy, and VA are purchasing CPG tool kits from the AMEDD to support their CPG implementation efforts.

The CPG topics selected for FY99 were tobacco use cessation, low back pain, hypertension, ischemic heart disease, asthma, COPD, hyperlipidemia, diabetes and depression. Selection of topics was based on high volume, high cost diseases/conditions common to all four organizations (VA, Army, Navy and Air Force). FY 00/01 topic selection included substance abuse, gastro-esophageal reflux disease (GERD), post-deployment health evaluation and management (to include chronic fatigue syndrome and fibromyalgia), uncomplicated pregnancy, dysuria in women and the prioritization of metrics for clinical preventive services. CPGs for psychoses and acute post-operative pain management are under development. FY02 conditions selected for guideline adaptation include stroke, opiates in the management of chronic pain, and the third component of the post-deployment guideline package --post-traumatic stress disorder (PTSD).

The DoD/VA CPG Working Group is committed to ensuring the currency of the evidence depicted in its guidelines and has a policy of updating its guidelines every two years. Guidelines slated for update in FY02 include hypertension, diabetes, low back pain, asthma, COPD, and tobacco use cessation. All FY99 and FY00/01 guidelines have been completed with the exception of psychoses and GERD.

The implementation of guideline usage begins with dissemination of guidelines to the field. However, the actual successful implementation requires a much more aggressive process. Improvements have been developed to optimize the guideline adaptation process, to ensure scientific validity, to decrease time to guideline completion, to facilitate use of guidelines by providers, and to assure primary care provider participation in the multi-disciplinary guideline adaptation process.

Overall the DoD/VA CPG Working Group has been extremely successful adapting and developing provider tools to support the implementation of 16 guidelines, developing two highly utilized websites hosting six 2-hour satellite broadcasts to support guideline dissemination and implementation. The partnership between DoD and VA has made guideline development initiative such a success.

However, only guidelines that have been implemented at the clinic and facility level can have any impact on patient outcomes. The Army Medical Department worked with the RAND Corporation to develop the best method for implementing the adapted DoD/VA practice

panels of physicians and allied healthcare providers are the backbone of the adaptation and implementation efforts described below.

The DoD/VA CPG initiative is in line with the Institute of Medicine's (IOM) recommendation to ensure the effectiveness of health care via the use of clinical practice guidelines, as described in its publication Crossing the Quality Chasm (March, 2001). It is also consistent with recent Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), National Council on Quality Assurance (NCQA), Institute for Healthcare Improvement (IHI) and Healthcare Quality Forum initiatives regarding evidence-based practice. From a resource management and guideline validity standpoint, practice guidelines are best done centrally at the system-wide level. Clinical practice guidelines can also assist in improving patient safety, another concern of the IOM outlined in its publication, To Err Is Human (December, 2000) by decreasing errors of omission and commission.

The Army Medical Department (AMEDD) is the designated executive agent for the Department for the DoD/VA Clinical Practice Guideline Working Group, a sub-group of the DoD/VA Executive Council (DoD/VA EC). The Working Group initiated its effort in June 1998 after an exploratory meeting held in February 98. The deliverables of the Working Group included:

- Development of a practice guideline working group charter;
- Selection of guideline topics;
- Coordination of the adaptation of guidelines by expert clinicians from all Services and the VA;
- Coordination of the selection of the guideline process and outcome metrics by expert clinicians;
- Organization-specific implementation; and,
- Development of a process of monthly collection and quarterly reporting of metrics to the DoD/VA EC.

The DoD/VA CPG Working Group Charter was signed by the Assistant Secretary of Defense (Health Affairs) and the Under Secretary for Health, Department of Veterans Affairs, in February 1999. The majority of DoD/VA CPGs are primary care CPGs targeted at high cost, high volume conditions for the DoD and VA.

dental insurance plans, the Services and TMA recognize marketing efforts are required to encourage higher utilization of the program.

TABLE 24: The TRDP - Enrollment and Utilization as of Dec 2001

	Covered Lives	Utilization
TRDP	690,000	59.0%

Data Source: Delta Dental Plan of California

As of the end of November 2001, the TRDP contractor had randomly mailed 22,925 customer satisfaction surveys with Explanation of Benefit statements. Beneficiaries completed 5,374 surveys for a 23.4 percent return rate. The results are depicted in Table 25.

TABLE 25 - Beneficiary Satisfaction with the Enhanced TRDP (Cumulative through Nov 2001)

	Percent Satisfied
Overall Program Satisfaction	74%
Program Benefits	63%
Availability of Dentists	77%
Program Materials/Communications	69%
Customer Service	82%

Data Source: Delta Dental Plan of California

It appears that there is a level of dissatisfaction with the TRDP that is inconsistent with high levels of satisfaction with the TDP or military direct dental care. These data are not easily explained. They may, however, relate to the fact that the beneficiaries carry the full burden of costs for this program; there is no government subsidy. The TMA should further analyze the data and consider improvements in future contracts.

Clinical Practice Guidelines

Practice guidelines are identified strategies with which to ensure and improve the quality and the cost-effectiveness of the care provided in the TRICARE MHS. They form the basis of all population health prevention and condition management initiatives. Evidence-based practice guidelines define the "right thing to do" and are focused on the quality of care. The objective of any CPG-based condition management program is to decrease unnecessary variation. Expected outcomes are improved quality of care, reduced demand for care related to that condition, and more appropriate utilization of clinical resources.

There are currently two major initiatives within the DoD regarding CPGs. They are the DoD/VA Clinical Practice Guideline Working Group and the Army Medical Department/RAND Corporation Practice Guideline Implementation Project. Tri-Service and VA multi-disciplinary

Table 22 displays the top five dental services used by enrollees. Beneficiaries primarily use diagnostic and preventive services followed by restorative and orthodontic services.

TABLE 22 - TDP Utilization - The Top Five Dental Services (1 Feb 01 - 31 Jan 02)

Type of Dental Service	Number of Services Used
Diagnostic	2,333,444
Preventive	2,199,498
Restorative	688,864
Orthodontic	480,190
Oral Surgery	185,376

Data Source: United Concordia Companies, Inc.

Table 23 portrays the FY 2001 TDP beneficiary satisfaction measures. Monthly, a random sample of 1,500 beneficiaries is selected from the continental United States that used the TDP within the last 90 days. The contractor forwards this sample to an external vendor to conduct and analyze the surveys. The results indicate broad satisfaction with TDP services. Lower satisfaction rates with the enrollment process and management of inquiries may be related to early problems encountered during the transition from the former contract in February 2001. The TMA plans to continue to monitor these satisfaction measures.

TABLE 23 - Beneficiary Satisfaction with the TDP as of Jan 02

	Network Access	Provider Network	Claims Processing	Enrollment Process	Written and Telephone Inquiries
Total Average Satisfaction	94%	91%	95%	90%	88%

Data Source: United Concordia Companies, Inc.

The TRICARE Retiree Dental Program (TRDP)

Public Laws 104-201 and 105-056 established a dental benefits program offering affordable basic and preventive dental coverage for Uniformed Services retirees and their eligible family members. The TRICARE Retiree Dental Program (TRDP) began February 1, 1998. On October 1, 2000, Public Law 106-065 enhanced the scope of benefits to form the most unique program of comprehensive dental care ever available to the military retiree population. The Federal Services division of Delta Dental Plan of California administers this voluntary dental plan. The TRDP offers dental coverage throughout the 50 United States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands, and Canada. The 2001 utilization rate for the TRDP was 59 percent (Table 24). Thus, approximately 40 percent of enrollees in this program did not use its benefits. Although this rate is greater than the national utilization rate of 54 percent for civilian

of dental caries in an individual by estimating how much the dentition has been affected by dental caries. This index is calculated for either 28 or 32 teeth.

- These differences are statistically significant ($p<0.01$).
- 1994 DMFT = 6.6, 2000 DMFT = 5.4

The 2000 survey results compare favorably to the 1994 survey results. Despite the slight improvement cited in the 2000 survey, the fact that 47.5 percent of new recruits have significant dental problems (Dental Class 3) that temporarily disqualifies them from worldwide deployment remains very worrisome. Upon accession, military recruits continue to present with significant oral disease.

Purchased Care Dental Programs

The TRICARE Dental Program (TDP)

The TMA awarded the TDP contract to United Concordia Companies, Inc., on April 14, 2000, for a base contract period and five, one-year option periods. The TDP replaced the TRICARE Family Member Dental Plan and the TRICARE Selected Reserve Dental Program; it began providing dental coverage on February 1, 2001. The TDP is government subsidized and the government pays 60 percent of the premium for most enrollees. It offers an affordable dental insurance program available to over three million eligible beneficiaries.

The TDP provides a comprehensive benefit package that is uniform and portable worldwide. The program offers a broad range of dental procedures with emphasis on prevention of oral disease. The utilization rate of the TDP for calendar year 2001 was 52.5 percent (Table 21). Thus, almost half of DoD beneficiaries in this program do not utilize its benefits. Although this rate closely tracks the national utilization rate of 54 percent for civilian dental insurance plans, the Services and TMA recognize the importance of marketing efforts to encourage higher utilization of the TDP.

TABLE 21 - The TDP – Enrollment and Utilization as of Dec 01

	Covered Lives	Utilization
TDP	1.6 Million	52.5%

Data Source: United Concordia Companies, Inc.

TABLE 18 - MHS Results for FY 2001 - DTF Perspective

Measure	Results
D1: Patient Satisfaction with Quality of Oral Health Care at the DTF	99%
D2: Patient Satisfaction with Interpersonal Relations at the DTF	98%
D3: Waiting Times at the Appointment at DTF	99%
D4: Waiting Time for an Appointment at DTF	90%
D5: Satisfaction with Access to DTF Providers	90%
D6: DTF Patient Propensity to Return to DTF for Care	97%
D7: Overall Satisfaction with DTF	97%
D8: Overall Satisfaction with Dental Care Received at DTF Visit	97%

TABLE 19: TOPS Measures D4 and D5 by Service

TOPS Measure	Reporting Period	Results		
		Navy	Army	Air Force
D4	July through Sep 01	95%	90%	84%
D5	July through Sep 01	93%	88%	90%

Data Source: TRICARE Operational Performance Statement (TOPS)

A complete description of each measure and how the results were calculated can be found at the TRICARE Operational Performance Statement's (TOPS) website under "Handbook" http://www.tricare.osd.mil/reptcard/tops/topsrept.html. This website also contains quarterly TOPS reports for each military DTF for FY 2001.

The Tri-Service Recruit Comprehensive Oral Health Survey

In 2000, the TSCOHS conducted a Recruit Comprehensive Oral Health Survey and findings from the survey were reported during FY01. Dental public health specialists at the TSCOHS analyzed data from dental examinations on 4,346 randomly selected recruits and compared the 2000 results with results from the 1994 Tri-Service Recruit Comprehensive Oral Health Survey. The major findings follow:

- There was no major difference in the Dental Health Status of 2000 Recruits compared to 1994 Recruits (Table 20). In Table 20, the percent Dental Class 1 difference is statistically significant ($p<0.01$), but the percent Classes 2 and 3 differences are not statistically significant.

TABLE 20 - Comparison of Military Recruit Dental Health Status

Year	Dental Class 1	Dental Class 2	Dental Class 3
1994	0.6%	50.1%	49.3%
2000	1.8%	50.7%	47.5%

Data Source: TSCOHS

- The mean number of decayed, missing and filled teeth (DMFT) for 2000 Recruits decreased slightly when compared to 1994 Recruits. DMFT describes the prevalence

Table 17 demonstrates that the dental emergency rate for Dental Class 1 patients is less than half the rate for Dental Class 2 patients and one-tenth the rate for Dental Class 3 patients. Nearly 30 percent of Dental Class 2 patients with dental caries will become Dental Class 3 if not treated within 12 months.

TABLE 17 - Emergency Rate as a Function of Dental Classification

Dental Classification	Emergencies per 1,000/Year
1	85
2	192
3	749

Data Source: "Longitudinal Study of DoD Recruits CY 1994-1998" by the Tri-Service Center for Oral Health Studies (TSCOHS), USUHS

Declining health demands increasingly expensive medical and dental interventions throughout the accession to retirement continuum. Dental wellness strengthens overall population health and underscores the importance of optimal dental health as a DoD goal. Fortunately, the TRICARE Management Activity and the Services' Dental Corps Chiefs directed an Integrated Process Team to identify required resources and submit a Tri-Service phased implementation plan to attain a 65 percent Class 1 Dental Health Standard by the end of FY09. This standard requires the Services to focus on improvement of the ADSMs' dental health (Dental Class 1) and rewards optimization and dental health promotion initiatives.

Beneficiary Satisfaction with Dental Care

During FY01, the Tri-Service Center for Oral Health Studies (TSCOHS) managed the DoD Dental Patient Satisfaction Survey for the TRICARE Management Activity (TMA). TSCOHS analyzed 194,610 completed surveys in FY01. Military Dental Treatment Facilities (DTF) worldwide provided these surveys randomly to patients who received care immediately following a dental appointment (Point of Service). Surveyed beneficiaries included ADSMs, family members of ADSMs, military Retirees, and family members of Retirees. Survey results (Table 18) indicate that patients are very satisfied with the dental care they receive in military DTFs. Table 19 demonstrates, however, that the Army and Air Force have lower rates of satisfaction with access to care than the Navy. The data portrayed come from the TRICARE Operational Performance Statement, which is discussed later in the report. The relative perception of some dissatisfaction with access to care may be related to recruitment/retention problems within the Army and Air Force Dental Corps.

Direct Care Dental Programs and Dental Clinical Quality Initiatives

Dental Health and Readiness

In January 1996, the Tri-Service Dental Corps Chiefs established a Dental Readiness goal that required the Services to maintain at least 95 percent of all active duty personnel in Dental Class 1 or 2 categories. These categories represent the proportion of the active duty forces available for deployment. The Services have significantly improved the dental readiness of Active Duty Service Members since that time. Figure 10 portrays the improvement in dental readiness from FY97 – FY01.

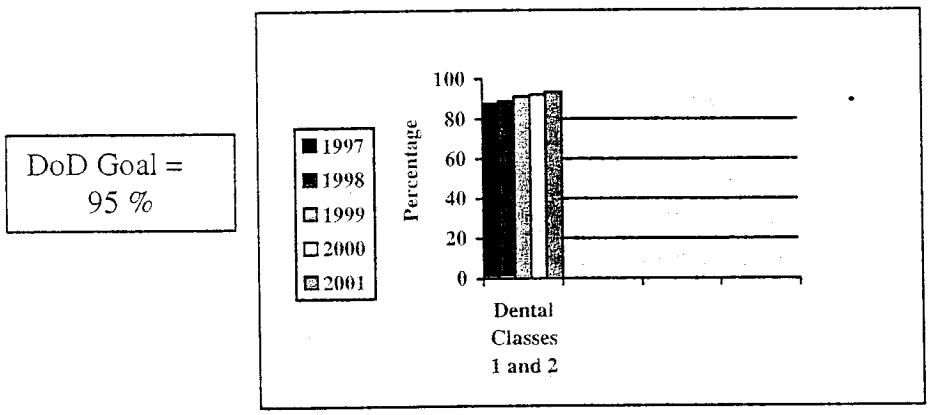


FIGURE 10 - Dental Readiness from FY 1997- FY 2001

The improvement in combined Dental Class 1 and 2 rates results in a 93.4 percent Tri-Service average for FY01. With the exception of the Navy, however, the Services have not yet achieved the 95 percent goal. Active Duty Service Members (ADSMs) with Dental Classes 3 or 4 are temporarily disqualified for deployment. This represents about 6.6 percent of the active duty forces. The Army and the Air Force Dental Corps have experienced significant problems with recruitment and retention of dentists, which may have impacted their ability to achieve DoD's readiness goal. Table 16 depicts the FY01 authorizations and end strength for each Service.

TABLE 16 - FY01 Dental Authorizations and End Strength

	FY 01 Authorizations	FY 01 End Strength
Navy	1369	1348
Army	1138	1004
Air Force	1092	985

Data Source: The Services' Dental Corps

Overall, as indicated in Figure 11, only 37 percent of the Active Duty Force was in Dental Class 1 in FY01. A lower Dental Class 1 percentage and higher Dental Class 2 percentage reflects a less than optimal state of dental health or complete dental wellness. Active Duty Service Members (ADSMs) with Dental Classes 3 or 4 are temporarily disqualified for deployment.

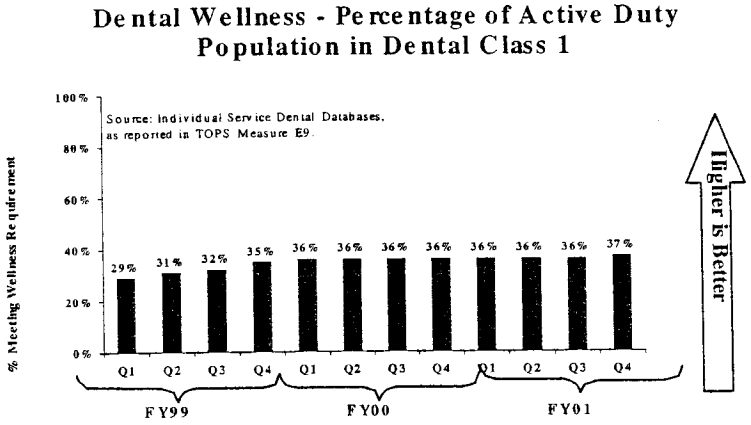


FIGURE 11 - Dental Wellness – Percentage of Active Duty in Class 1

Optimal dental health (dental wellness) enhances force health protection by reducing the burden of illness and disability for ADSMs. Several studies indicate that dental conditions represent between 10 percent and 20 percent of the total sick call population in a contingency operation. During the Persian Gulf War, urgent or emergent dental problems caused lost duty time for many ADSMs. At one deployable medical hospital in Saudi Arabia, dental emergencies accounted for 1,400 out of 10,000 patient visits. Among soldiers in heavy combat operations, dental emergencies resulted in the average loss of five man-days per emergency visit.

In 2001, as portrayed in Table 14, all referrals began to be counted, in addition to the high dollar cases and the number soared to 110.

Table 14 - MCSC Case Referrals for 2001

Contractors	Region	States	Total Referrals
Sierra	1	CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, VT, North VA	4
Anthem Alliance	2 & 5	IL, IN, KY, MI, OH, WV, WI, St. Louis, MO, NC, South VA	0
Humana Military (as of 6/01)	2 & 5	IL, IN, KY, MI, OH, WV, WI, St. Louis, MO, NC, South VA	8
Humana	3 & 4	FL, GA, SC, AL, LA, MS, TN	52
Health Net	6	Eastern & Central TX, AR, OK, Southern LA	11
TriWest	Central 7 & 8	AZ, CO, IA, KS, MN, MO, MT, NE, NV, NM, ND, SD, UT, WY	5
Health Net	9, 10, & 12	CA, AK, HI	9
Health Net	11	ID, OR, WA	18
UCCI	National	National Dental Contractor	1
Humana	Overseas	Overseas	2
Total Cases for 2001			110

TMA Program Integrity Activity Report, 1999-2001

Table 15 portrays the results of TMA PI's activities over the last three calendar years. The launching of OPERATION TRICARE Fraud Watch in late 1999 with its increased emphasis on anti-fraud programs had an impact on the earlier identification of fraud, thus minimizing dollar losses within the program. The National Health Insurance Association of America has estimated that for every $1 spent on anti-fraud activities, $11 is saved.

Table 15 - Program Integrity Activity Report

Description	1999	2000	2001
Qui Tams	256	181	141
Civil Cases Settled	92	138	61
DoD Hotlines	32	11	31
Written requests for consultation, case support, or assistance from DCIS, DOJ, and other law enforcement entities	584	600	532
Cases referred to DCIS	202	128	122
Cases referred to Military Criminal Investigative Offices	8	5	5
Balance Billing and Violations of Participation Agreement	57	29	42
Providers Sanctioned	2,976	2,709	3,756
TRICARE dollars identified for recovery (includes directed administrative recoupment)	$2,900,000	$1,120,000	$11,200,000

administrative actions taken by the managed care support contractor. Table 12 shows a breakout of each contractor, the number of providers on prepayment review, and the dollars saved by the prepayment review.

TABLE 12 - Providers on Prepayment Review

Time Period	Contractor	Number of Providers	$ Saved
January 2001 – December 2001	Health Net Federal Services, Region 6	23	$660,682
January 2001 – December 2001	Health Net Federal Services, Region 11	2	$7,106
January 2001 – December 2001	Health Net Federal Services, Region 9, 10 and 12	32	$434,407
January 2001 – December 2001	Tri West Healthcare Alliance (Region 7 & 8)	23	$78,496
January 2001 – December 2001	Humana Military Healthcare Services (Region 3 and 4)	146	$3,371,518
January 2001 – December 2001	Humana Military Healthcare Services (Region 2 and 5)	67	$730,835
January 2001 – December 2001	Sierra Military Health Services (Region 1)	23	$179,221

Contract Oversight and Compliance

To develop a more effective fraud and abuse detection, prevention, and referral program among the MCSCs, TMA PI expedited implementation of Chapter 14 of the TRICARE Managed Care Support Contractor Operations Manual. The requirements outlined in Chapter 14 reflect the increased emphasis on healthcare fraud and abuse. Chapter 14 standardizes specific categories of actions required by the contractor to ensure uniformity. To operationalize this plan, TMA PI appointed four program integrity staff members to function as Alternate Contracting Officer Representatives (ACORs) to oversee implementation of the new antifraud requirements. ACORs are responsible for technical issues surrounding program integrity in connection with administration of the contract. ACORs are also responsible for tracking a contractor's progress in compliance with Chapter 14 as well as performing on-site inspections, ongoing surveillance, and monitoring performance. Additionally, the appointment of a Senior Healthcare Fraud Specialist in charge of Contractor Compliance and Oversight enhances the potential for continuous improvement in fraud detection and intervention.

In 2001, ACORs continued to provide assistance and education to each managed care contractor while performing contract oversight to ensure compliance with Chapter 14. Site visits enabled the ACORs to establish rapport with the staffs of the contractors' program integrity

offices and to observe hands-on utilization of the artificial intelligence software. Since implementation of the software TMA has seen an increase in the number of fraud cases referred for review and further referral to the Defense Criminal Investigative Service.

The Program Integrity staff visited and trained Lead Agent staff from Regions 1, 2/5, 3/4, 6 and 7, the Office of the Inspector General in Hampton, Virginia, as well as personnel at Johns Hopkins University Uniformed Services Family Health Plan.

The TMA Program Integrity Office publishes a monthly "Spotlight" report to provide ongoing education and guidance to the contractors' program integrity units.

In calendar year 1999, prior to TMA PI receiving the ACOR designations, there were only 11 fraud referrals from all of the contractors. Table 13 reflects the doubled increase in case referrals from the MCSCs in 2000.

Table 13 - MCSC Case Referrals for 2000

Contractors	Region	States	CY 2000
Sierra	1	CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, VT, North VA	0
Anthem	2 & 5	IL, IN, KY, MI, OH, WV, WI, St. Louis, MO, NC, South VA	2
Humana	3 & 4	FL, GA, SC, AL, LA, MS, TN	6
Foundation	6	Eastern & Central TX, AR, OK, Southern LA	4
TriWest	Central 7 & 8	AZ, CO, IA, KS, MN, MO, MT, NE, NV, NM, ND, SD, UT, WY	3
Foundation	9, 10 & 12	CA, AK, HI	2
Foundation	11	ID, OR, WA	0
UCCI	National	National Dental Contractor	3
Humana	Overseas	Overseas	2
Total Cases for 2000			22

of $528,171,896 for all federal programs for FY 2000. The following vignettes illustrate successful recovery efforts.

LifeScan® - Faulty Glucose Monitoring Equipment

A *qui tam* suit against LifeScan, Inc.®, a blood glucose home-monitoring device manufactured by Johnson and Johnson, resulted in a successful recovery effort. The relator alleged that the senior management of Lifescan® and Johnson and Johnson were aware of faulty programming which lead to inaccurate blood glucose readings used to assess glucose control and to calculate insulin dosage. Inaccurate blood glucose readings can result in a diabetic emergency of profound hypoglycemia or diabetic ketoacidosis with life-threatening consequences. The Department of Justice negotiated a $30 million dollar settlement on behalf of all federal programs including a $1.8 million dollar award to TRICARE.

TAP Pharmaceuticals - Charging for Free Samples

Lupron® is a medication primarily used in the treatment of women diagnosed with endometriosis or uterine leiomyoma. Pharmaceutical companies regularly provided doctors with free samples of these medications to encourage them to prescribe the medication to their patients. Some of the physicians breached ethical duties and violated the law by charging patients for these free samples of Lupron. Through the use of TRICARE's national database, it was determined that TMA beneficiaries paid cost-shares for the "free samples." These "free samples", cost-shared by the government, resulted in an unnecessary expenditure of taxpayer dollars. The Department of Justice represented the interests of TMA in this matter and judgment was returned for TAP Pharmaceuticals to pay $854 million in damages to all affected programs. TRICARE's recovery was $101,000 dollars.

Valley Counseling - Services not Rendered

Everseley Haswell of Valley Counseling of Colorado pled guilty to two felony counts of Healthcare Fraud, one felony count of Conspiracy to Defraud with Respect to Claims, and one felony count of Criminal Forfeiture. His wife, Karla Haswell, also of Valley Counseling of Colorado, pled guilty to one felony count of Healthcare Fraud and one felony count of Conspiracy to Defraud with Respect to Claims. This culminated a six-year investigation of Valley Counseling. This billing fraud scam involved filing claims for services not provided and using an authorized provider's identification to submit claims for services that, when rendered, was done so by an unauthorized provider. Principals, Everseley and Karla Haswell were

submitting false claims to TRICARE and Medicare for mental health counseling that was not being provided. TRICARE will recover approximately $498,339 dollars in damages. Mr. Haswell received a sentence of 21 months' imprisonment and three years released supervision. Karla Haswell received six months' home detention and five years' probation.

Fraud Recoveries

Thus far, TRICARE has received judgments for $11.2 million dollars for calendar year 2001. The dollars returned are shared with the MCSCs at the rate of approximately 20 percent of the dollars recovered, depending on the dates of care involved in the judgment and the terms of the contract. Another $1.6 million resulted from administrative recoupment. The remaining dollars are disbursed among the various branches of the Uniformed Services as TRICARE benefit dollars.

Case of the Year Award

The TRICARE Case of the Year Award recognizes excellence in the detection and resolution of health care fraud. Award criteria include the development and referral of the case by a TRICARE contractor or fiscal intermediary, acceptance by DCIS and successful prosecution or settlement by Department of Justice. The Program Integrity Staff of Palmetto Government Benefits Administrators (PGBA), a member of the DCIS, and two Assistant United States Attorneys (AUSAs) from the Eastern district of Virginia received the 2001 TRICARE Case of the Year Award for their development and referral of Consultants in Nutritional Services (CNS) for investigation. A Health Care Benefits Advisor from the Oceana Medical Clinic, Oceana Naval Air Station, Virginia Beach, Virginia, received recognition for initiating the referral that resulted in the investigation.

CNS was providing nutritional counseling and weight loss management to its clients, neither of which is covered under TRICARE, Medicare, or TRIGON (a Blue Cross/Shield Company). CNS claims circumvented the edits designed in the three programs to identify exclusions. The claims falsely depicted the provider of services and disguised the actual services provided.

Prepayment Review

Prepayment Review is one of the strategies used by the Managed Care Support Contractors to prevent the expenditure of money that would have paid for questionable billing practices or fraudulent services. Providers are placed on prepayment review as part of the

"providers" includes all types of individual and institutional healthcare services: hospitals, ambulance companies, home nursing programs, durable medical equipment vendors, medical suppliers, pharmacies, physicians, mental health counselors, podiatrists, physical therapists, etc. Fraud can adversely impact quality of care and result in patient harm when "profit" is put ahead of what may be in the best interests of the patient. The following vignettes illustrate this point.

Lab Sink Test

The "lab sink test" scenario occurs when normal results are reported on untested lab specimens that are poured down the sink. With disregard for the welfare of the patients involved, the lab keeps administrative costs low and maximizes profits by engaging in this scheme. Patients on the other hand may experience delays in being properly diagnosed that could result in permanent impairment or even death. The "lab sink test" scenario impacts the beneficiaries and subscribers of both private and public plans.

Adulterated Medication or Biologicals

During 2001, authorities discovered a pharmacist with pharmacies in Kansas and Missouri who diluted cancer chemotherapy drugs. TMA PI immediately explored the possibility of TMA beneficiaries being affected by this fraudulent practice. Although no TRICARE patients received these adulterated chemotherapeutic agents, TMA PI alerted TRICARE Service Centers at Fort Riley, Fort Leavenworth, and Whiteman AFB to prepare for beneficiary questions.

In a California case, TRICARE patients received diluted well-baby immunizations. The pediatric corporation acknowledged that they had diluted childhood vaccines for a period of approximately two and one-half years and that the dilutions were done with the specific intent to defraud patients and the insurance providers. Until this admission, scores of patients and their families doubted these allegations. Of the nearly 4,000 patients identified, only 400 were actually tested to determine their level of immunity. Of these 400, approximately 66 percent had inadequate immunity from Hepatitis B. TMA PI and the MCSCs assisted local authorities in notifying military families of the need to retest those children who had been immunized by this provider to verify adequate levels of immunization.

Whether it is the indiscriminate prescribing of addictive drugs, diluting chemotherapy or well-baby vaccine injections, patient notification is an essential aspect of a corrective action for a healthcare fraud scheme.

The above scenarios exemplify the two priorities of TMA PI – identification of potential patient harm cases (regardless of the dollar amount) and non-patient harm cases involving large dollar losses. This identification process facilitates TMA to direct its limited resources toward ensuring that military families receive quality healthcare in a cost-effective manner. By continuing to share information with other government agencies and the private sector, healthcare fraud can be brought under control, thus contributing to the ability to provide affordable, quality healthcare to all citizens of the United States.

TRICARE's National Database

To respond to those who investigate or prosecute fraudulent practices, TMA PI uses a TRICARE database, the Health Care Service Record (HCSR), which maintains information on covered beneficiaries and health care providers. The HCSR facilitates the investigation of allegations of fraud and abuse through analysis of a suspected provider's billing patterns and an assessment of the cost for use by the Department of Justice in its settlement negotiations.

The HCSR is derived from data forwarded by TRICARE MCSCs in a specific format that is run against a specific set of edits. Although the data requirements contribute to data integrity and the fiscal soundness of a single audit trail, the extensive information required places an administrative burden on the MCSCs. Therefore, with the implementation of the next generation of contracts, the TRICARE Encounter Data System (TED) will replace HCSRs. TED will be the new, streamlined, collection of purchased care data from the contractors that will be used to meet government requirements for health care information. Implementation of TED will comply with the requirements cited in the National Defense Authorization Act for Fiscal Year 2001 and will promote efficiencies and cost savings for the contractors and the government. TED will also improve TMA's ability to implement the Health Insurance Portability and Accountability Act of 1996 requirements, provide for more timely access to purchased care data, and capture critical fields such as the National Drug Code, Referring Physician, and National Provider ID.

Relationship with the Defense Criminal Investigative Service

In Fiscal Year 2001, TRICARE provided services for 8.2 million eligible beneficiaries worldwide. The healthcare budget for the Department of Defense of $18.1 billion covers the Military Treatment Facilities and non-defense facilities. Federal healthcare programs working collaboratively were able to identify $145,380,671 in criminal cases and $830,155,023 in civil cases for a grand total of $977,200,553 federal dollars in judgment. This compares to judgments

program. Distribution is restricted to Department of Justice, Defense Criminal Investigative Service and other investigative agencies.

During 2001, the TMA PI opened 311 new cases, responded to 532 requests for assistance, evaluated 141 new *qui tam* cases and closed 387 cases. Qui tam is a provision of the Federal Civil False Claims Act that allows private citizens to file lawsuits in the name of the U.S. Government charging fraud by government contractors and others who receive or use government funds and share in any money received. This unique law facilitates the effective identification and prosecution of government procurement and program fraud and the recovery of revenue lost as a result of the fraud.

TRICARE's Operation Fraud Watch

In September 1999, TMA PI launched TRICARE's Operation Fraud Watch at a fraud training conference held in Myrtle Beach, South Carolina. The Myrtle Beach site was chosen to promote attendance at the conference by TRICARE's largest claim processor, Palmetto Government Benefits Administrators (PGBA) located in Florence and Surfside Beach, South Carolina. Representatives attended from most of TRICARE's prime contractors including Anthem Alliance Health Insurance Company; Foundation Health Federal Services, Inc.; Humana Military Healthcare Services; Sierra Military Health Services; and United Concordia Company, Inc., and the two claims processing subcontractors, PGBA and Wisconsin Physicians Service (WPS).

This initial conference, attended by various government agencies that work together to combat fraud, resulted in an agreement between TMA and the Defense Criminal Investigative Service (DCIS) to alternate sponsorship of the conference.

The Executive Director of TRICARE Management Activity attended the press conference announcing the Columbia Hospital settlement in December 2000. The Attorney General of the United States publicly recognized and praised TMA's contribution to the investigation and settlement that resulted in a return to TRICARE of $7.4 million.

Training and Educational Efforts

On January 1, 2001, TMA PI launched the TRICARE fraud and abuse web page at http://www.tricare.osd.mil/fraud/home/cfm. Topics covered on the web site include fraud and abuse news releases, frequently asked questions, access to the TRICARE Sanctioned Provider List, a link to the Department of Health and Human Services Consolidated Provider Sanction

List, and fraud and abuse links. Beneficiaries and providers may also report allegations of fraud through a direct link to the managed care support contractor's program integrity fraud unit. Between March 27, 2001 and January 1, 2002, 4,880 individuals contacted the web site. A sample of the website pages is contained at Appendix B.

In August 2001, TMA PI hosted the third TRICARE Healthcare Fraud Conference in San Diego, California. Presenters from the Department of Justice, Defense Criminal Investigation Service, the Federal Bureau of Investigation, TMA's Program Integrity Office and others provided a comprehensive training course on healthcare fraud information. The audience consisted of investigators, attorneys, and industry experts.

In conjunction with the April 2001 Fraud Conference, TMA PI conducted a series of three 2-hour training courses for the beneficiary population, the first-ever Beneficiary Fraud Awareness Forum. Guest speakers included Congresswoman Susan Davis and Major General Jan C. Huly, USMC, Commander of the Marine Corps Recruit Depot in San Diego. Course content included information about TRICARE for Life (the opportunity for eligible members over 65 to regain TRICARE eligibility as a second payer to Medicare), fraud and abuse, resources available at TRICARE Service Centers, and resources available at the Lead Agent's Office.

TMA PI takes an active role in training and educational efforts related to fraud and abuse. In 2001, TMA PI provided fraud and abuse training as well as computer and technical program support to more than 3,100 people. In attendance were representatives from the following organizations: Department of the Army, Department of the Air Force, Department of the Navy, United States Coast Guard, Defense Criminal Investigative Service, Department of Justice, Federal Bureau of Investigation, Department of Health and Human Services, and organizations outside of the federal government. Speakers from the TMA PI provided training at the TRICARE Basic and Advanced Student Course, the Federal Health Care Acquisition Conference, multiple Lead Agent conferences, the orientation for the Lead Agent Medical Directors, training for Defense Criminal Investigative Service and the annual TRICARE Conference.

Impact of Fraud on the Quality of Care

Although a relatively small percentage of providers commit healthcare fraud, the dollar impact is estimated to be in the range of 3 to 10 percent of all healthcare expenditures. The term

in the number of errors and other problems reported. However, it is very important to note that any increase identified is not likely due to an increase in harm to patients, but to a change in culture encouraging more open reporting of near misses and actual events.
Patient safety measures are much less developed than measures in most areas of health care. Therefore, new process and outcome measures are essential. The DoD is working with the QuIC, the NQF, and others on these measures.

The rollout of the Patient Safety Program continues in FY 02 with six training sessions planned. Approximately 70 patient safety managers will be hired to support the program in MTFs. While the AFIP supports the Patient Safety Center with existing resources, additional staff will be hired including a MHSPSC Director, with training and experience in patient safety. The MHSPSC will assist in designing a new database system that will allow an easier reporting process for the facilities. Additionally, the MHSPSC will revamp their website and improve data management and analysis of the database system. USUHS plans to establish a Center for Patient Safety Education and Research. This center will work closely with the AFIP and the Services. In addition, this will enable USUHS to expand their educational work including residency training and continuing education for physicians, nurses, and a variety of other health professionals.

Ten additional hospitals will begin to use the MedTeams program in their Emergency Departments. The Air Force will deploy the Medical Team Management program to all of their hospitals with high-risk areas in FY 02. Following that, deployment will start in other Air Force facilities and in Army and Navy facilities. DoD will work with the other QuIC agencies and IHI on another Breakthrough Series on improving safety in ambulatory care with the participation of an estimated 28 DoD teams.

Performance Improvement – Clinical and Process Outcomes

Program Integrity

The TRICARE Management Activity (TMA) Program Integrity Office (PI) is the centralized administrative hub for fraud and abuse activities involving purchased care worldwide for beneficiaries of the Defense Health Program. PI is responsible for developing policies and procedures regarding prevention, detection, investigation and control of TRICARE fraud, waste and program abuse, monitoring contractor program integrity activities, coordinating with DoD and external investigative agencies and initiating administrative remedies as required. PI is located in the Acquisition Management and Support Directorate.

TMA PI provides technical assistance and guidance to the DoD Office of the Inspector General (IG) for Investigations and to U.S. Attorneys in developing cases for prosecution, to include expert witness testimony. Through a Memorandum of Understanding (MOU), PI refers provider fraud cases to the Defense Criminal Investigative Service (DCIS). PI coordinates investigations with offices and agencies of the Department of Justice, DoD IG, various Military Departments and federal, state and local agencies and administers the administrative procedures related to provider exclusions, suspensions, terminations and reinstatements. PI is the principal point of contact for research, analysis, and coordination of DoD "Hotline" complaints.

A member of the National Healthcare Anti-Fraud Association (NHCAA) TMA PI shares fraudulent billing schemes with other private and public healthcare plans. December 2001 marked the first time in its 16-year history that the NHCAA selected TMA PI as the public sector representative to the Executive Committee, representing the entire public sector that includes the Veterans Administration, Office of Personnel Management-IG, and the Center for Medicare and Medicaid Services. TMA PI is also the TRICARE Liaison Member of the Department of Justice Healthcare Fraud Working Group. TMA PI works with the FBI, state investigative agencies, and the numerous healthcare fraud task forces established throughout the United States. These healthcare fraud task forces have representatives from the full spectrum of government and private healthcare plans.

Periodically, TMA PI publishes a newsletter with a focus on the development, investigation and prosecution of health care fraud cases. The newsletter also provides information about TRICARE to maximize awareness and recovery of money through the PI

- Establish a MHS Patient Safety Center (MHSPSC), to include an MHS Patient Safety Registry (MHSPSR), through the AFIP;
- Establish a Patient Safety Council;
- Establish two Centers of Excellence (COEs) in the MHSPSC to develop programs to improve communication, coordination, and teamwork;
- Comply with requirements for confidentiality of medical quality assurance regulations (10 U.S.C. 1102); and,
- Establish a Healthcare Team Coordination Program.

DoD Health Affairs established the MHS Patient Safety Center at the Armed Forces Institute of Pathology (AFIP). The five pilot sites forwarded their reports to the Patient Safety Center in FY 01. Preliminary reports indicated that medication errors were the most commonly reported problem followed by patient falls. A substantial proportion of errors were not easily categorized and as a result the classification process is undergoing refinement. The MHSPSC website (www.afip.org/PSC) averages 1,000 user-sessions per month. In August 2001, the center published the first issue of a quarterly newsletter with an electronic and print distribution of approximately 1,500 people. The AFIP also focused on patient safety in a 2001 issue of their publication, *Legal Medicine*.

The Healthcare Team Coordination Program is sponsored by the MHSPCS as well. The program currently has two components: MedTeams and Medical Team Management. MedTeams, a team-training program developed by Dynamics Research Corporation, initially focused on emergency departments. A version for use in obstetrics is under development. Medical Team Management, developed at Eglin Air Force Base, is a team-training program designed for use throughout the facility. A revised version of the program is being developed for use throughout the Air Force, Army and Navy. The revised version features a combination of web-based instruction and facilitated discussions.

DoD played a key role in the initiation and planning of an Institute for Healthcare Improvement Breakthrough Series on Improving Safety in High Hazard Areas. The project focused on rapid cycle quality improvement to improve safety in labor and delivery, operating rooms, intensive care units and emergency departments. The Quality Interagency Coordination (QuIC) Task Force collaborated with the Institute for Healthcare Improvement (IHI) in sponsoring this project. Forty-six teams participated from the DoD, DVA, Healthcare Financing

Administration (HCFA) (now known as the Center for Medicare and Medicaid Services (CMS)), and AHRQ. Nineteen DoD teams included ten from the Navy, five from the Army, three from the Air Force, and one from the Uniformed Services University of Health Sciences (USUHS) and the Office of the Assistant Secretary of Defense for Health Affairs. The collaborative included five administrative teams that sought to assist clinical teams in their work and to spread innovations. This first use of administrative teams in an IHI Breakthrough Series proved to be very successful. Administrative teams will be included in future IHI programs.

The Navy team introduced a new practice to improve neonatal resuscitation at 19 Navy facilities. The Army team built on the work of one of their clinical teams to develop a training package with a videotape and CD-ROM on improving the safety of magnesium sulfate administration for use in facilities worldwide. The Health Affairs/USUHS team focused on improving the DoD patient safety program training and publicizing the program.

Several other DoD initiatives are underway to improve patient safety. The Composite Health Care System (CHCS) II, the DoD electronic medical record, will improve patient safety by expanding computerized physician order entry, increasing the availability of clinical information, and providing decision support. The worldwide implementation of the Pharmacy Data Transaction System greatly increases the ability to detect drug interactions and therapeutic duplications before they can harm a patient. USUHS is making a number of changes in their curriculum, which includes usage and access to their simulation center. Simulators allow physicians, medical students and others to practice new skills without risking harm to patients. DoD is also involved in a number of projects with members of the Quality Interagency Coordination (QuIC) Task Force. In 2001, QUIC activities included initiatives to improve communications with consumers about patient safety, the development of patient safety metrics, the Federal Credentialing Project, and a conference on workplace issues. In addition, DoD has participated in patient safety work with a variety of other organizations including the Leapfrog Group, the National Quality Forum (NQF) and the Health Benefits Education Campaign.

The MHS Patient Safety Program made significant progress in FY 01. However, there still remains a great amount of work to be done. A chief problem is the underreporting of medical errors and other types of preventable events. This is not a problem unique to military hospitals as underreporting is very common in the civilian healthcare sector. Currently, no reliable baselines or benchmarks exist. A good reporting system may cause a dramatic increase

The PDTS currently processes over 350,000 transactions per day, over 130 million to date. While the 45,000 *potential* drug-drug interactions represented only about 0.03 percent of the total transactions to date, they are those that may not have been identified *prior* to the activation PDTS due to the lack of a central repository. Therefore, the benefit that comes from identifying these interactions prior to dispensing medications and avoiding potential life-threatening complication associated with these drug interactions provide our DoD patients an immediate reduction in risk and safer more effective care.

The DoD Patient Safety Working Group and the MHS Patient Safety Center

On November 30, 1999, the Institute of Medicine (IOM) issued a landmark report, *To Err is Human*, which drew attention to the high rate of errors in health care. The IOM recommended the following actions to manage this serious epidemic:

- Establish a national focus to enhance the knowledge base;
- Identify and learn from errors through mandatory and voluntary reporting systems;
- Raise standards and expectations for improvement in safety; and,
- Create safety systems in health care organizations.

In response to the IOM report, President Clinton issued an Executive Memorandum on December 7, 1999, directing the Secretaries of Defense, Health and Human Services, Labor and Veterans Affairs, and the Director of the Office of Management and Budget to take further steps to improve patient safety.

In response to the national focus on patient safety, the Assistant Secretary of Defense for Health Affairs (ASD (HA)) formed the DoD Patient Safety Working Group (PSWG) in 2000. The composition of the PSWG includes representatives from the Services, Uniformed Services University of the Health Sciences (USUHS), Armed Forces Institute of Pathology (AFIP), Health Affairs, and TRICARE Management Activity. These representatives are qualified and experienced physicians, nurses, risk managers, attorneys, pharmacists, and experts in preventive medicine and information management. Experts from the Department of Veterans Affairs (DVA), the Agency for Healthcare Research and Quality (AHRQ), and others served as consultants for the PSWG. The tasks for these consultants were to:

- Review patient safety issues in the MHS and identify current initiatives;
- Prepare an instruction creating a confidential reporting system; and,
- Recommend further action.

The PSWG identified the need for creating a "culture of safety" as a key attribute to promote patient safety within the MHS. The current approaches in the MHS and in the entire American healthcare system blames providers for medical errors and promotes secrecy of such incidents. To promote a "culture of safety", PSWG proposed an approach based upon education and communication. The new approach accepts that clinicians make mistakes, focuses on errors within systems (includes policies, procedures, and processes), and promotes openness. It focuses more attention on "near miss" incidents. "Near miss" incidents are potential adverse events that have not yet harmed or reached the patient. "Near misses" reveal many of the vulnerabilities in these systems. If these vulnerabilities are noted and corrected, problems that could cause serious harm can be averted.

Furthermore, an effective reporting system is essential to analyze patient safety incidents. The PSWG developed a system modeled after the Department of Veterans Affairs (DVA) system. The system provides a confidential and non-punitive database of these occurrences with a focus on identifying and solving problems within a system. Sharing lessons learned throughout the MHS is essential to prevent further adverse events.

The PSWG conducted a pilot test on five facilities from October 15, 2000, through April 15, 2001 at the National Naval Medical Center, Walter Reed Army Medical Center, Nellis Air Force Base, Fort Meade, and Fort Belvoir. These facilities integrated the concept of a "culture of safety" and the new reporting system into their daily business practices. Coincidental with the pilot test, the PSWG offered a Patient Safety training session to the entire MHS including the pilot sites beginning in October 2000. Based on the results of the pilot test and the first training session, the PSWG revised the training that is now ongoing.

The Department of Defense issued Instruction 6025.17 "Military Health System Patient Safety Program" on August 17, 2001. This document provided guidance and stipulated requirements for the MHS Patient Safety Program. The requirements outlined are to:

- Emulate the DVA system of reporting, compilation, and analysis of errors in the provision of healthcare;
- Prescribe procedures in each Military Treatment Facility (MTF) to avoid medical errors and improve patient safety; focus on prevention and improvement of medical systems and processes to overcome preventable errors (root cause analysis);
- Require MTFs to have a Patient Safety Program;

DoD Patient Safety Programs

Prior to the establishment of the Institute of Medicine Committee on the Quality of Health Care in America, the DoD recognized the need for and focused on increasing patient safety in dispensing medications to patients. Over several years DoD successfully created an integrated system of pharmaceutical care across the spectrum of the worldwide direct care military treatment facilities, retail networks and the national mail order pharmacy program sites. A second initiative focused on other multidisciplinary aspects of patient safety. These two programs are described below.

Enhancing Patient Safety with the Pharmacy Data Transaction Service

The Pharmacy Data Transaction Service (PDTS) improves the quality of the Department of Defense (DoD) prescription service and enhances patient safety by reducing the likelihood of adverse drug-drug interactions, therapeutic drug overlaps, and duplicate treatments. The PDTS provides an aggregate screening capability across the highly transient population of active duty and retired MHS beneficiaries. To accomplish this, the PDTS conducts an on-line prospective drug utilization review against a patient's complete medication history for each new or refilled prescription before it is dispensed to the patient. Information about these prescriptions is available to authorized PDTS providers as a seamless enhancement to the current workflow processes. This initiative is unprecedented in connecting high-level and disparate pharmacy systems resulting in higher quality medical care, reduction of fraud and abuse, and better information for managing the pharmacy benefit.

The implementation of the MHS integrated pharmacy system began with the development of a centralized data repository and a common drug profile for all DoD beneficiaries, accomplished through a contract with WebMD®, a private sector pharmacy claims manager. The program for the movement of data between the MHS activities and WebMD® gave the integrated program its name, the Pharmacy Data Transaction Service.

Since June 25, 2001, the PDTS was fully deployed to all DoD MTFs, Managed Care Support Contractors and the National Mail Order Pharmacy Program sites. Under the PDTS, all MHS pharmacy points of service (MTFs, MCSC retail network pharmacies, and the NMOP contractor) have been required to electronically transmit selected patient, drug, and provider data elements to WebMD®. The data are transmitted over communication lines using national standard message codes established by the National Council of Prescription Drug Programs.

With these transmissions, WebMD® builds centralized patient profiles within the integrated data repository. Each MHS activity is required to receive additional standard codes for warning messages and alerts generated from these transactions. During this process, PDTS conducts on-line prospective drug utilization reviews (clinical screenings) against the patient's complete medication history for each new or refilled prescription *before* it is dispensed. The clinical screenings identify the potential for any two or more prescriptions to have a drug-drug interaction, therapeutic duplication, and/or too early a refill. The screenings also monitor for excessive or insufficient dosing, as well as well as under- or over-utilization.

The PDTS is currently in use at more than 350 MTFs, 40,000 network pharmacies and 13 NMOP sites worldwide. Wherever a patient's prescription is filled within the MHS, the information about that prescription is sent to the PDTS for clinical screening and stored in the central data warehouse. From April 2000 through the end of July 2002, the PDTS processed 129,466,375 prescriptions. During this same time period, over 45,000 *potentially* life-threatening drug interactions were identified. The potential interactions are flagged for clinical intervention and resolution by the provider or at the dispensing pharmacy. These notifications resulted in an overall reversal rate of 10.6 percent of the 45,000 potential drug interactions. The fact that the PDTS performs these clinical drug screenings online in real-time without disrupting patient care has been a major factor in its success.

To safeguard the privacy of patient information, all stored historical pharmacy data and transactions sent between the PDTS and DoD pharmacies are encrypted to meet the privacy and security standards required by the Health Insurance Portability and Accountability Act. The average transaction time from prescription order entry to encrypted transaction response, is 3.1seconds for sites within the Continental United States (CONUS) and 3.8 seconds for sites outside CONUS.

The prescription information stored in the PDTS central repository ensures providers have access to a complete medication history when necessary and data for conducting historical reviews. Authorized users can also securely access the central data repository and tailor reports based on any of the data elements. For the first time, the MHS has access to outpatient prescription data from a single source and the ability to monitor prescription utilization throughout the MHS and provide almost instantaneous reports to analyze that utilization.

policy or direction from Congress (usually via an appropriation). Congressionally mandated research is the subject of a separate annual report to Congress and will not be addressed in this report.

The goals of clinical investigation are to:

- Improve the quality of health care;
- Generate an atmosphere of scientific inquiry;
- Promote an academic environment of high professional standing; and,
- Provide a means to assist in the accreditation of Graduate Medical Education programs.

The following DoD Directives (DoDD) govern clinical investigation within the Military Health System (MHS):

- DoDD 6000.8, Funding and Administration of Clinical Investigation Programs, November 2, 1999;
- DoDD 3216.1, Use of Laboratory Animals in DoD Programs, April 17, 1995; and,
- DoDD 3216.2, Protection of Human Subjects in DoD-Supported Research, January 7, 1983.

Title 32, Code of Federal Regulations, Part 219, Protection of Human Subjects, is the DoD implementation of the Common Rule that follows the Food and Drug Administration and Health and Human Services regulations. Studies using human subjects are approved and monitored by Institutional Review Boards (IRB) at each medical center. Studies using animals are approved and monitored by Institutional Animal Care and Use Committees at each medical center. There were 4,560 active protocols underway across the three Services during 2001. All TRICARE military hospitals and research facilities are in compliance with the above directives.

Problem-Knowledge Couplers®

Computerized Decision Support Information Technology (DSIT) tools are computer programs that aid clinical decision-making. Problem-Knowledge Couplers® are examples of DSIT technology. However, the military health system requires evidence about the DSITs' effect on quality, cost, and satisfaction before committing to the tools' widespread implementation. Therefore, the Department contracted with the Yale Center for Outcomes Research and Evaluation (CORE) to conduct a two-phase clinical study to evaluate the impact of

Problem-Knowledge Couplers® on clinical quality, resource consumption, and patient and provider satisfaction. Following an initial pilot study, phase one of this study commenced June 2001 and is expected to conclude in December 2002. A patient-randomized trial with a concurrent observational arm is now underway at two Military Treatment Facilities, Ireland Army Community Hospital, Fort Knox, Kentucky, and Mayport Naval Branch Medical Clinic, Mayport, Florida. Preliminary data from this study may be available for next year's annual report to Congress.

Health Evaluation Assessment Review (HEAR)

The Health Evaluation Assessment Review (HEAR) is a critical component of Department of Defense (DoD) Military Health System (MHS) Force Health Protection (FHP) and Population Health Improvement (PHI) strategies. It gathers self-reported health information on general health, chronic disease, health risk factors, and Clinical Preventive Services (CPS) requirements that are essential for provision of quality health care. The current questionnaire and process of administering the HEAR required review and improvement to keep up with evolving technology and changing needs of the DoD. The Department contracted with Yale Center for Outcomes Research and Evaluation (CORE) to do a top-to bottom review of the questionnaire and its administrative process.

Completed in May 2001, the results of the Yale review are currently being integrated with other Service-unique requirements and questions to produce a shorter, more effective, and purposeful HEAR questionnaire. This new HEAR will take full advantage of the future state computerized patient record Composite Health Care System (CHCS) II, and the Theater Medical Information Programs (TMIP) strategy for sharing information among service specific automated information systems. The revised HEAR will also use the Internet and the MHS electronic health (eHealth) Portal to increase access to all TRICARE Beneficiaries. The most significant change to the revised HEAR process however, will be the ability to store all the data in the single central data repository (CDR) for CHCS II. This will provide the first real opportunity to do enterprise-wide analysis and outcomes research on the health demographics of our TRICARE beneficiaries. Full implementation of the revised HEAR is projected for the first quarter FY 03.

Quality management specialists request additional medical records and other required documents, review the cases, and write detailed case summaries. Through a systematic review of PQIs, confirmed QIs are identified. Each QI is assigned an appropriate severity level and corrective action plans (CAPs) are developed, if necessary, to correct the root causes of variations. CAPs relate to institutions with identified patterns of PQIs and QIs, not generally to healthcare providers. Plans also include guidelines for monitoring to assure that the changes in practice or behavior have occurred. CAPs are formulated which may include:

- Provider education by oral or written contact or through further training;
- Provider re-certification for procedures which require certification;
- Required submissions of corrective action plan updates with subsequent monitoring to ensure compliance;
- Prospective or retrospective trend analysis of individual provider practice patterns;
- In-service training for providers or their staff;
- Provider contract changes that include modifications, suspensions, restrictions, or termination of participating privileges; and,
- Intensified review of individual provider care.

Each CAP is expected to have clearly stated goals, clearly stated objectives and timeframes for completion. The CAP is routinely forwarded to the institution or provider(s) involved. All QIs are reviewed monthly, or quarterly, in forums that include MCSC and Regional Director (Lead Agent) representation. Providers, identified to have quality issues, are tracked for any further quality issues. The MCSC is responsible to determine, implement, monitor and reassess all CAPs.

Physician Office Medical Record Audits

Many contractors monitor the quality of their physician providers through the performance of on-site medical record review. The selection of providers for individual review is often based on the volume of TRICARE beneficiaries assigned to them or based on the number of beneficiary visits within a calendar year or in response to documented quality issues.

Profiling of Provider Performance

Provider profiling is a method for tracking and monitoring individual provider performance. It usually involves the review of services rendered by the provider, but also may

include the identification and frequency of quality of care issues. Some networks produce profiling reports for both specialists and PCMs. For analytical purposes, they evaluate each provider against peer groups in comparable geographic and specialty areas. These reports then provide an analysis of each provider's variance from the peer group norm.

Challenges for Regional Quality Management

There are two major challenges for oversight of the quality management programs in the TRICARE regions. The first is prime source verification of credentials. The MCSCs have encountered difficulties regarding credentials management and provider profiling and the management of databases for credentialing purposes. The huge number of providers in the TRICARE networks has resulted in some inconsistencies in prime source verification and in sustaining centralized data elements for profiling purposes. Profiling is also encumbered by the fact that individual providers may provide care for very few TRICARE beneficiaries. Therefore calculation of performance rates is impractical. Though lacking systematic centralized data, the impression the contractor Medical Directors and our regional clinical quality staff is that the quality of providers in the networks is very good. Efforts are underway to create systematic performance measures that should more pragmatically reflect this impression over time.

Clinical Research

Clinical Research has been called the lifeblood of Graduate Medical Education (GME) and evidence based medicine. The DoD Clinical Investigation Program (CIP) provides military medical personnel the opportunity to participate in clinical research. The main focus of this program is the protection of TRICARE MHS beneficiaries through the monitoring of human use in research protocols. This is done through the investigational review boards at all military hospitals. Clinical research is important in obtaining accreditation by Residency Review Committees (RRC) reviewing GME programs. All RRCs are intently interested in how well the research component of the GME program is executed.

The TRICARE MHS is involved in a wide range of clinical investigation activities. The specific nature of the studies is largely determined at the Service or Uniformed Services University of the Health Sciences (USUHS) level. The Assistant Secretary of Defense for Health Affairs (ASD (HA)) neither determines which clinical studies shall be performed nor sets a research agenda. However, the ASD (HA) may provide focus to specific studies when necessary because of DoD

Improvement Needed

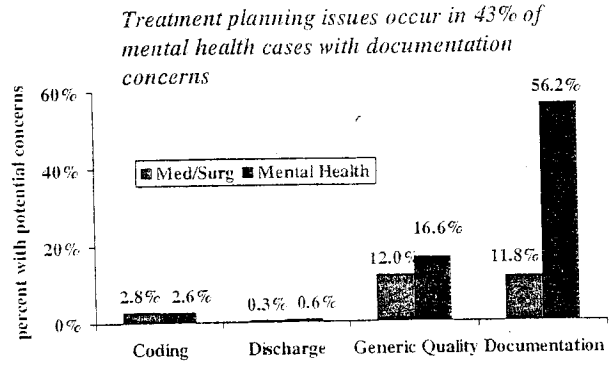


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FIGURE 9 - Improvement Needed

Network Quality Assessment Programs (Purchased Care)

Oversight of the MCSC and DP quality programs is at the Regional level through the offices of the TRICARE Regional Lead Agents. Data from the regional quality programs is not tracked centrally due to variances across the contracts. However, among improvements in the next generation of contracts is a requirement for centralized reporting of data based on uniform requirements for input to the annual quality management plans from the regions.

The following paragraphs describe the processes in place to assess important aspects of the quality of care offered through our purchased care programs. Currently, seven contracts serve 12 TRICARE regions covering the 50 states and the District of Columbia. Four different Managed Care Support Contractors (MCSC), some with multiple contracts, manage the health care delivery and monitor the quality of care provided within their respective TRICARE civilian network regions. Outside of the Continental United States (CONUS), oversight is structured through overseas MTFs which generally perform quality of care reviews on referred care and survey beneficiaries as to their satisfaction with civilian health care.

Each MCSC maintains a comprehensive Clinical Quality Management Program (CQMP). Each quality management program directs the monitoring of both institutional network providers and individual network providers. These plans provide a method to assure the monitoring and evaluation of health care quality, as reflected in the structure, process, and measurable outcomes of health care services delivered to beneficiaries within each region. The monitoring and

evaluation process is designed to examine both individual and institutional occurrences as well as to examine the quality of services trended over time.

Although the CQMPs differ among the seven contracts, they share similar core quality assessment program components. These core components include the monitoring of provider credentialing and recredentialing, monitoring of beneficiary grievances, completion of quality review studies, examination of all potential quality issues, review of physician office medical record audits and the profiling of provider performance.

Verification of Credentials and Current Competence

A fundamental network quality activity is the assurance that competent, qualified providers constitute the network. The TRICARE MCSC Operations Manual requires that no fewer than 85 percent of the audited files shall be in full compliance with all provider file requirements. Some networks require an initial site survey for each Primary Care Manager (PCM) prior to initial credentialing. For these providers, a site visit is performed prior to PCM recredentialing every two years.

Monitoring of Beneficiary Grievances

The MCSCs review and evaluate complaints from beneficiaries regarding the perceived failure of some part of the health care delivery system pertaining to access to care, availability of providers, acceptability, continuity and/or timeliness of care or service. The MCSCs fully investigate, identify all quality issues, develop quality action plans, and present them to the involved provider(s). Provider related issues are tracked for trending patterns.

Quality Review Studies

Many MCSCs perform annual quality review studies based on the analysis of data from sufficiently large populations collected over a sufficiently long period. Studies are based on identified clinical issues affecting specific target populations. Data collected from these studies enable the MCSCs to implement strategies for health promotion and education in both the patient and provider population.

Examination of Potential Quality Issue(s) (PQI)

PQI reviews are examinations into variances from expected provider performance and clinical care outside the parameters of professionally recognized standards. Upon evaluation, PQIs are determined to either be unmerited or are identified as actual Quality Issues (QIs).

Department initiatives, legislative and regulatory measures and Congressional hearings highlighted the need for quality assurance and utilization standards for residential treatment facilities, substance use disorder rehabilitation facilities, and partial psychiatric programs. In 1995, the Department spearheaded the creation of comprehensive standards for mental health facilities that encompassed staff qualifications, clinical practices, and all other aspects directly impacting the quality of care. Despite these standards, some mental health facilities though accredited by nationally recognized accrediting bodies, were shown to have unacceptable practices in the care of mental health patients. Therefore, the Department initiated a policy of unannounced onsite inspections to assess the compliance of facilities with the above noted standards. As the contractor for the NQMC, KePRO conducts these onsite surveys. Some of the deficiencies and problems discovered are as follows:

- Partial Hospitalization Programs which literally do not exist, but bill for partial hospitalization services as if they do;
- Residential Treatment Centers which allege they are an acute care facility if they are reviewed by an acute care entity or a residential treatment facility if they are reviewed by a residential treatment entity;
- Inappropriate mixing of populations of patients, housing very young children with adolescents, housing victims of abuse with perpetrators of abuse, placing partial hospitalization patients on inpatient and residential treatment units for the duration of their treatment;
- Questionable treatment modalities that include forms of sensory deprivation; and,
- Seclusion and restraint issues with evidence of patient injury, inadequate documentation, and poorly trained staff.

The application process for certification is electronic, user-friendly, and timely. As of March 2002, there are 100 TRICARE MHS certified mental health programs at 92 facilities. Twenty-eight Residential Treatment Centers (RTC) serve children and adolescents; 49 Partial Hospitalization Programs (PHP) serve all ages of patients; and 23 Substance Use Disorder Rehabilitation Facilities (SUDRF) serve all ages of patients. Between January 2001 and January 2002, 17 facilities applied for certification as TRICARE MHS providers. Eight were approved; eight were denied; and one application was returned due to erroneous JCAHO accreditation information about the facility. Although the number of initial applications has decreased

between calendar year (CY) 98 and CY 01, the approval of initial applications has increased. During this same timeframe, the number of applications for re-certification has remained consistent; the number of facilities requesting withdrawal has decreased. The criteria for onsite reviews of TRICARE MHS certified facilities include:

- Quality of care issues;
- Licensure or accreditation changes; and,
- Past termination of the facility by TRICARE
- Serious allegations against the facility;
- Significant number of incidents; and,
- Changes in the facility that signify instability.

Table 11 portrays the number of onsite surveys of mental health programs done by KePRO.

TABLE 11. Mental Health Programs Surveyed in CY 2001

Number of Mental Health Programs Surveys in CY 2001	
RTC	9
PHP	6
SUDRF	3
Total surveys in CY 01	15
Cumulative surveys since Aug 98	62

The results of the above surveys were as follows:

- 67 percent – successfully completed plans of correction;
- 13 percent – submitted plans of correction but required quarterly updates to substantiate compliance;
- 13 percent - required a repeat on-site survey or were proposed for termination; and,
- 7 percent – withdrew in lieu of submitting a plan of correction.

There are two major trends noted since 1998: a decrease in the number of facilities that request withdrawal in lieu of submitting a plan of correction – 42 percent withdrew in 1998; 6 percent withdrew in 2001 - and the number of deficiencies found during surveys has decreased.

Based on 2, 086 cases reviewed by KePRO (Figure 8), a substantial proportion of mental health documentation issues have to do with treatment planning deficiencies.

Contractor Responses to Potential Concerns

As outlined in their contracts with TMA, managed care support contractors and designated providers are required to respond to potential concerns. During the first few years, contractor response rates were low. Throughout the year 2000, KePRO, TMA, the managed care support contractors and designated providers worked collaboratively to increase contractor response rates. KePRO analyzed the responses received in previous years, determined several areas of concern, and shared these with TMA representatives during the first half of 2000. During the second half of the year, TMA visited each contractor and explored the process of responding to potential concerns as well as the response rates. At the same time, KePRO developed an electronic contractor response form and offered it to each of the contractors for their use. The primary purpose of the form was to increase responses, ensure consistency in responses, and simplify the response process for contractors. The results of these combined efforts are shown in Figure 6. The overall contractor response rate increased from 14 percent to 57 percent. Response rate for utilization concerns also improved from 32 percent to 79 percent.

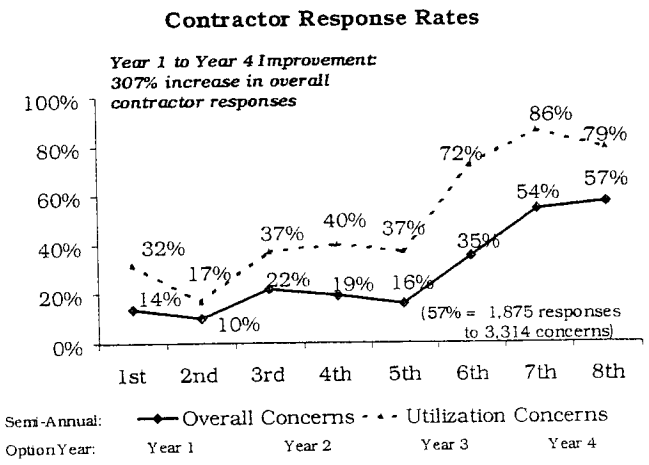

FIGURE 6 – Contractor Response Rates

Level of Agreement with KePRO Determinations

The increase in volume of contractor responses provided insight into the level of contractor agreement with the NQMC determinations. Contractors generally agree with the identified potential utilization and quality concerns. As Figure 7 indicates, contractors usually completely agree with KePRO. Partial agreement with KePRO is infrequent.

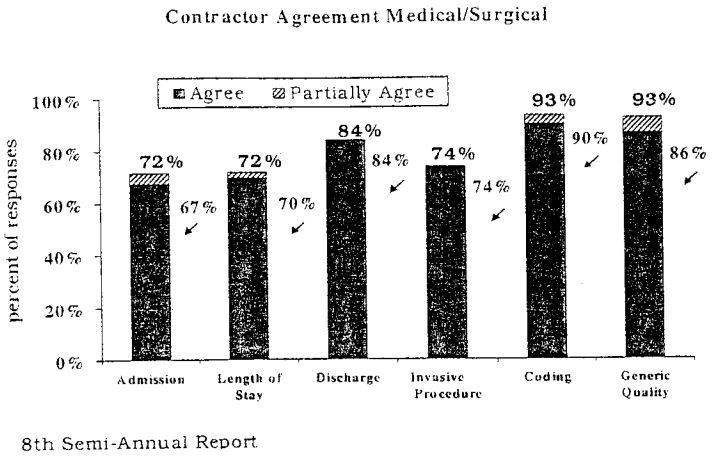

FIGURE 7 – Contractor Agreement Medical/Surgical

Appeal Decisions

When the MCSCs and DPs deny care based upon a determination that the care is not medically necessary, the beneficiary can ask the NQMC to perform a second level appeal review. That independent review by the NQMC has consistently upheld the denial in about 50 percent of the cases. Figure 8 shows the results for the most recent six-month period. It should be pointed out however, that KePRO may have access to additional information not previously provided to MCSC or DP and that there is some measure of disagreement between providers about what is appropriate for medical care.

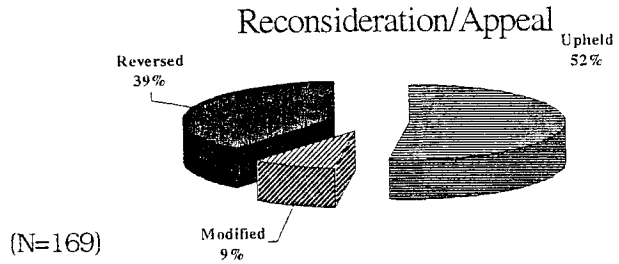

FIGURE 8 – Reconsideration/Appeal

Facility Certification

The National Quality Monitoring Contract is responsible for the certification of civilian facilities offering mental health services to our beneficiaries. Over the past ten years, a series of

screening criteria, it must be referred for a second review to confirm any potential utilization or quality concern. If there are potential utilization or quality of care issues, the Managed Care Support Contractor (MCSCs) and/or the Designated Providers (DPs) must review those findings and take any follow-up action as necessary.

The data portrayed in Figure 3 relates to the care provided by the Managed Care Support Contractors and the Designated Providers. The data reflected do not relate to care provided in military hospitals and clinics that are monitored separately by the Services. In approximately eighteen percent of cases, second level reviewers confirmed that potential quality concerns existed based upon the records submitted for review. These concerns were forwarded to the MCSCs or DPs for further analysis and additional supporting material if indicated.

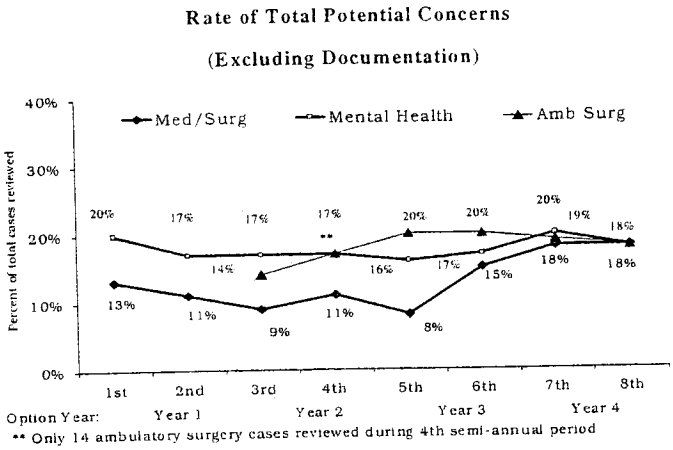

FIGURE 3 – Rates of Potential Quality Concerns - Purchased Care

The following section and figures address specific areas related to the potential quality and utilization concerns.

Medical/Surgical Length of Stay Potential Concerns

Steady improvement is noted for the length of stay reviews for Medical/Surgical cases. Initially 3.6 percent of all cases reviewed fell out for potential length of stay concerns. Following a downward trend, this rate is now 2.2 percent (Figure 4).

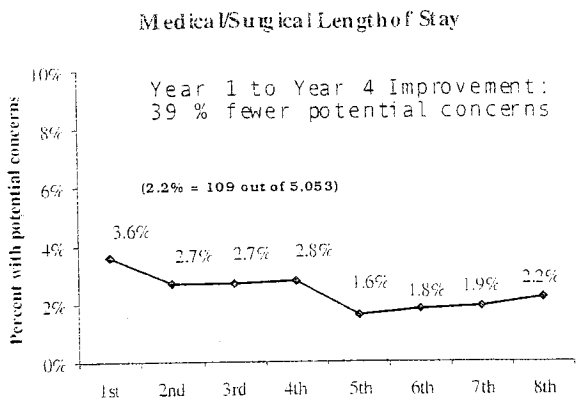

FIGURE 4 – Medical Surgical Length of Stay Discrepancies

Admission Denial Disagreements

Another area showing significant improvement is in the area of Admission Denial reviews (Figure 5). Initially, the NQMC reviewers disagreed with 10 percent of all Admission Denial cases. These are cases for which the MCSCs initially denied authorization for admission to a hospital based on medical necessity information available at the time of admission. As depicted in Figure 4, over the course of four years, the rate of disagreements dropped steadily to the current rate of 4.8 percent. Given the annual caseload of 608 reviews, the 4.8 percent equates to 29 admission denials. Although there appears to be some disagreement about admission denials, the rate has dropped by more than 50 percent.

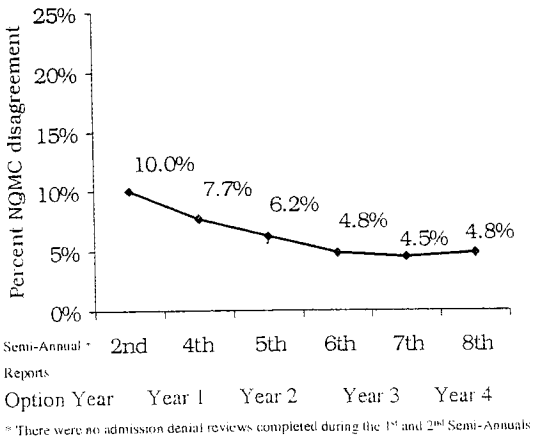

FIGURE 5 – Admission Denial Disagreements – Purchased Care

for a group of testing sites. For instance the Pediatrics Department at a specific MTF may hold a single CLIP certificate for the newborn nursery, pediatric clinic, neonatal intensive care unit, and well baby clinic, etc.

The College of American Pathology issues CAP accreditations. Every DoD inpatient hospital clinical lab holds a CAP accreditation. The Food and Drug Administration (FDA) registration is required for all transfusion services. An FDA license is required for all blood donor centers that ship blood across state borders. Either the FDA registration or license is held by all of our blood banks. The American Association of Blood Banks (AABB) accreditation is not required but some MTFs have acquired this additional credential. Table 10 portrays the total number of DoD laboratories and blood banks and the types of certification or accreditation they hold.

Table 10 - Lab and Blood Bank Certification/Accreditation

April 2002	CLIP Certificates	CLIP Sites	CAP Accreditation Certificates	FDA Registered	FDA Licensed	AABB Accreditation Certificates
DoD Total	1,490	2,994	348	76	36	69

National Quality Monitoring Contract

The National Quality Monitoring Contract (NQMC) is an indefinite delivery/indefinite quantity contract awarded as a fixed-price contract to Keystone Peer Review Organization (KePRO) in Harrisburg, Pennsylvania. The contract contains a base performance period from the date of the award, August 29, 1997, through October 31, 1997, and five (5) one (1)-year option periods commencing on November 1, 1997, and continuing through October 31, 2002.

The primary focus of the NQMC is the purchased care component of the TRICARE MHS except as previously discussed under the previous NPDB Reporting section. The purpose of this contract is to assist the TRICARE Management Activity and the Lead Agents by providing an independent impartial evaluation of the health care provided to the TIRCARE MHS beneficiaries by:

- Validating utilization management decisions;
- Monitoring the quality of care provided to ensure that quality standards are met and that health care delivered to beneficiaries is not compromised by financial incentives;

- Providing an external second level appeal of denials made by Military Treatment Facilities (MTFs), Designated Providers (DPs), and the Managed Care Support Contractors (MCSCs);
- Providing an external, independent review of paid MTF malpractice cases (see NPDB Reporting section of this report);
- Conducting facility certification activities for Residential Treatment Centers, Psychiatric Partial Hospitalization Programs, and Substance Use Disorder Rehabilitation Facilities to include onsite surveys; and,
- Providing peer review for the TRICARE Management Activity. These cases are usually derived from contractor decisions to deny coverage.

The NQMC is an integral part of the TRICARE Quality and Utilization Review Peer Review Organization structure. This Program is designed to assure the quality and appropriateness of health care services under the TRICARE as established in Chapter 32 of the Code of Federal Regulations, Part 199.15. According to Title 10 of the United States Code section 1079(o)(2),

> "The Secretary of Defense...may adopt or adapt for use under the CHAMPUS Peer Review Program...any of the quality and utilization review requirements and procedures that are used by the Peer Review Organization under part B of title XI of the Social Security Act (42 U.S.C. 1030 c et.seq.)."

The peer review system uses criteria developed on both national and local levels to determine the adequacy and appropriateness of care. The criteria have been revised over time but continue to be specific and unique to the TRICARE population and benefit.

Over the last three years, KePRO reviewed more than 58,000 medical records: approximately 43,000 medical/surgical reviews and approximately 15,000 mental health reviews relating to purchased care administered by our MCSCs. KePRO publishes a semi-annual report that summarizes these reviews. Trend analysis of data from the semi-annual reports offers evidence of several areas of healthcare quality improvement.

KePRO performs a retrospective review on the cases using the medical record as submitted by the provider. Each case undergoes a screening review based upon specific criteria for utilization review and quality management. If the case does not meet all of the first-level

TABLE 8 - Rate of Malpractice Payments per Facility

	Number DoD Paid Cases	Rate*	Number non-DoD Payments**	Non-DoD Rate***
1997	294	2.8	18,298	3.1
1998	288	2.7	17,681	3.0
1999	349	3.8	19,020	3.3
2000	255	3.3	19,493	3.6
2001	303	3.9	NA	NA
	Average	3.3		3.2

* *Rate is number of payments or paid malpractice claims per hospital*

** *Source: 2000 Annual Report of the National Practitioner Data Bank*

*** *Non-DoD Rate based on Hospital Statistics – American Hospital Association data: 5,810 hospitals nationwide in 1999*

In addition to participation in the NPDB and the continuation of the KePRO external review program, DoD also has worked steadily to improve its primary risk management research tools – the malpractice and adverse clinical privileging action databases. These two databases developed in the 1980s provided a great deal of clinical information regarding both the DoD medical malpractice experience and the type of adverse privilege actions within DoD. These two databases comprise the Defense Practitioner Data Bank. Currently, they are being converted into CCQAS. This will greatly expand DoD's ability to analyze information in a more timely fashion using web-based system. It is expected that these two databases will be converted later in 2002 and representative data will be provided in a future report to Congress.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and ORYX™

In the United States, the JCAHO is the nationally recognized organization that surveys healthcare settings based on published criteria and provides an accreditation status based on the onsite surveys conducted at least every three years. Participation in the JCAHO survey process is an institutionalized aspect of quality for the Services for many years. Typically, survey scores for MTFs exceed 90 (out of a possible score of 100) even if there are requirements for improvement identified in some areas. A transformation in the preparation for a JCAHO survey is underway. The current emphasis is on sustained performance, using the JCAHO standards as the benchmark for healthcare practice in our institutions. Having adopted the model of continuous process improvement, MTFs are expected to be in a state of accreditation readiness. Just as we 'train as we fight' for wartime or military operations other than war, the intent of the accreditation process today is to ensure that our organizations:

- Establish and maintain mechanisms to perform important processes and functions;

- Measure those processes and functions to assess effectiveness; and,
- Influence the continuous improvement in the performance of those important processes and functions.

The scores for the TRICARE military hospitals are compared to civilian and federal facilities. The average JCAHO scores for 2000 and 2001 are displayed in Table 9.

TABLE 9 –TRICARE MHS Aggregate JCAHO Scores CY 2000 and 2001

	Hospitals		Ambulatory Care Facilities	
	2000	2001	2000	2001
Military Hospitals	92 (24)	92.6 (34)	96 (22)	93.8 (26)
Non-Military Hospitals	90.8(1513)	91.3 (1508)	93.3 (396)	93.6 (539)

The number in parentheses indicates number of facilities surveyed by JCAHO.

ORYX® is the name of the JCAHO initiative that integrates performance measures into the accreditation process. It does this by providing a critical link between onsite accreditation and ongoing clinical care represented by various outcomes data. The purpose of ORYX® is to guide and stimulate continuous process improvement in healthcare settings through the use of core measures that facilitate benchmarking and feedback from the JCAHO to individual facilities. Four initial core measures were announced in April 2001:

- Acute Myocardial Infarction
- Heart Failure
- Community Acquired Pneumonia
- Pregnancy and Related Conditions

Data collection is expected to start July 2002 with Quarter Three 2002 data due to JCAHO by January 31, 2003. The MEDSTAT Group, Inc. is the vendor selected by the Department to abstract and transmit MTF data to JCAHO. Appendix A contains the specific sets of measures to be collected.

Laboratory Certification

The DoD Clinical Laboratory Improvement Program (CLIP) certificates are the equivalent to the Clinical Laboratory Improvement Act (CLIA) certificates that civilian laboratories maintain as required by law. Every DoD lab, which tests human samples for the diagnosis and/or treatment of disease, worldwide, has a CLIP certificate. These certificates are issued and renewed based upon successful inspection by the College of American Pathologists (CAP), JCAHO or another suitable inspection program. A single CLIP certificate may be issued

Table 7 - Malpractice Report Rates to the NPDB –
Comparison between DoD and Civilian Providers

Year	DoD Physician Malpractice Reports to the NPDB *	DoD Rate: Physician Malpractice Reports per 1,000 Physicians **	Civilian Providers Mean Rate: Physician Malpractice Reports per 1,000 Physicians ***	Civilian Providers Rate Range: Physician Malpractice Reports per 1,000 Physicians ****
1997	32	2.4	20.1	6.0 to 38.5
1998	127	9.5	21.2	5.7 to 37.2
1999	86	7.2	NA	NA
2000	64	5.1	NA	NA
2001	110	9.1	NA	NA

**Data Source: National Practitioner Data Bank*

***Data Source: Number of Physicians from US Medicine: Federal Market Facts – includes MDs, Doctors of Osteopathy (DOs), and residents*

****Data Source: National Practitioner Data Bank 1998 Report, Table 9. Rate depicted is the mean of the rates of all of the states*

*****Data Source: National Practitioner Data Bank 1998 Report, Table 9. Rate depicted is the range of the states' reporting rates. Rates rounded to nearest tenth of a percent.*

NA: Rate data were not available in the National Practitioner Data Bank 1999 or 2000 reports. The NPDB adopted a position of only reporting raw numbers for individual states instead of rates. Therefore, in future years, we shall not produce this rate comparison.

In 1998, DoD began a program of external review of DoD malpractice cases by the Keystone Peer Review Organization (KePRO). The Services send cases to KePRO for evaluation in instances where the Services have determined that the standard of care was met or in cases that involved a system (non-provider) problem. KePRO provides an external review of the standard of care. In calendar year 2001, KePRO reviewed 559 DoD providers. KePRO agreed with the Services' determinations of the standard of care for 478 or 86 percent of the providers. The high agreement rate, in our view, supports the accuracy and validity of reviews by the Services. This program has resulted in an increase in the number of provider names submitted to the NPDB.

There are a number of reasons why KePRO makes a determination that the standard of care was not met when Service reviewers have determined that the standard of care has been met. The primary reason is that determinations are a matter of judgment, and it is not uncommon for different reviewers to have varying opinions regarding the standard of care. Reasonable reviewers can differ in their opinions regarding the standard of care.

In order to improve tracking of paid malpractice cases, DoD entered into an agreement with the Department of the Treasury. This agreement facilitates the transfer of a timely listing of recent payments by the Judgment Fund Branch for DoD medical malpractice cases. This is an important source of our data regarding malpractice. Figure 2 represents the number of paid DoD medical malpractice cases for 1997 through 2001. The data does not include foreign claims, claims under $100,000; claims paid under the Military Claims Act or small payments under $2,500 paid under the Federal Tort Claims Act. It does include the great majority of DoD malpractice payments and the pattern does not reveal an increasing trend over the five years portrayed. Though 303 malpractice claims were paid in 2001, only 144 of these resulted in reports on providers to the NPDB as previously discussed.

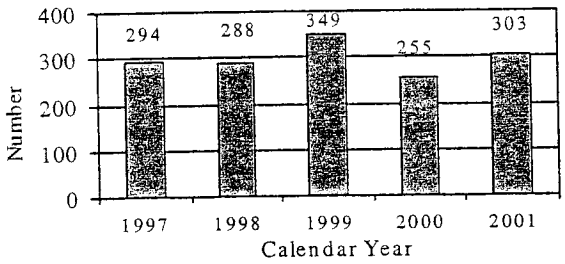

FIGURE 2 - DoD Medical Malpractice Paid Cases 1997 – 2001

Note: The Judgment Fund does not include foreign claims, claims under the Military Claims Act, paid under the Military Claims Act, or small payments under $2,500 paid under the Federal Tort Claims Act. Five year average = 298 claims

Table 8 compares the rate of malpractice payments per facility in DoD with similar non-DoD hospital data. The DoD malpractice payment rate per facility is similar to the non-DoD hospital rate

Medicare/Medicaid exclusions. Established September 1, 1990, the intent of the NPDB is to restrict the interstate relocation of unscrupulous healthcare practitioners. It is intended to facilitate disclosure or discovery of information exposing potentially damaging or incompetent performance. Authorized registered healthcare entities (hospitals, health maintenance organizations, licensure boards, professional societies, and peer review bodies) query and report specific information related to malpractice payments and adverse privileging actions on healthcare providers to the NPDB. The Department of Defense participates in NPDB through a memorandum of understanding (MOU) between DoD/Health Affairs and DHHS. In addition to adverse privileging actions, DoD submits reports to the NPDB whenever the Surgeon General of a particular Service determines that the standard of care has not been met in a specific case involving a paid malpractice claim.

From 1997 through 2001, DoD reported malpractice payments and clinical privilege actions to the NPDB as shown in Table 5. The aggregate number of reports from the Services average 77 malpractice payments per year. The wide variability in year to year reporting is dependent upon many factors including some variation of processes used by the Services, case-mix complexity, and a recent - though now for the most part resolved - case evaluation backlog. On a national basis, the private and public sectors submit a total of 18,000 – 20,000 malpractice reports per year to the NPDB. On the average, the Services report an aggregate of 44 cases per year of clinical privileging actions.

TABLE 5 - DoD Reports to the National Practitioner Data Bank CY 1997 - 2001

Year	Malpractice Payments	Clinical Privileges Actions
1997	46	58
1998	146	54
1999	102	39
2000	77	30
2001	144	40

Source: The National Practitioner Data Bank

Table 6 displays cumulative provider malpractice payments by DoD to the NPDB over the past five years. Cumulative totals include those prior to 1997 dating back to 1991 when DoD began participation. Not reflected in this table are malpractice payments based on system (non-provider) problems.

TABLE 6 – Cumulative Malpractice Payment Reports to the NPDB

Year	Annual Malpractice Payment Reports	Cumulative Malpractice Payment Reports
1997	46	314
1998	146	460
1999	102	562
2000	77	639
2001	144	783

Reported providers include physicians, dentists, and other non-physician healthcare providers. Nationally, physicians represent the majority of reports to the NPDB (82 percent).

Table 7 shows rates of physician, in contrast to all healthcare providers, reports to the NPDB for the DoD and the United States. The rate of malpractice reports on behalf of DoD physicians per 1,000 physicians falls below the mean rate for civilian physicians. DoD malpractice reports to the NPDB, however, do not include Feres-barred cases that involve active duty service members. By statute, DoD cannot report these cases to the NPDB because DoD has made no malpractice payments. The Feres Doctrine, developed in 1950, established that the government could not be sued under 50 different state law rules for accidental injuries to soldiers who were already covered by military benefits. Under Feres, the government and its military officials are immune from tort claims by military personnel for harms arising out of military service.

Finally, DoD does not report malpractice payment cases to the NPDB if the Services Surgeons-General determine that the standard of care has been met based on clinical case reviews. In these instances, payment has been made because of a decision by the Department of Justice to proceed with payment rather than litigation. This policy balances the civilian practice of "corporate shield" that limits reporting of healthcare providers when the co-defendant healthcare organization provides malpractice coverage for the co-defendant employee practitioner. Approximately 50 percent of military paid medical malpractice cases have not been related to variances from the standard of care by military healthcare providers.

TABLE 4 – TRICARE MHS GME Accreditation

Yrs accredited	# GME Programs	Percent Accredited per Duration of Accreditation
1	1	0.5%
2	15	7.9%
3	33	17.4%
4	47	24.7%
5	94	49.5%
N/A	5	
Pending	15	
Total	205	

Credentials Review and Privileging Activities - CCQAS

The Centralized Credentialing Quality Assurance System (CCQAS) is a database application that validates and maintains the credentials of military and civilian healthcare providers. CCQAS supports the credentialing and privileging activities of the Services and the MTFs and meets the DoD directives and the Joint Commission accreditation requirements. CCQAS is designed to ensure optimum theater clinician assignment, to "get the right person to the right place at the right time". As it evolves and expands to include data from the Reserve Components, CCQAS should expedite the transfer of privileged providers for temporary or permanent changes of assignment. Lastly, CCQAS will store and track adverse actions and malpractice information and thus will serve as a risk management repository for the Department. Representative data from CCQAS shall be reported in a future report to Congress.

Competency Based Technical Training Programs

Verification of current competence is an essential aspect of assessment of the ability of a provider to perform in a high-quality, safe, and effective manner. Although the assessment of current competence for physicians, dentists, and other healthcare providers takes place formally every two years when institutional privileges are renewed, the process entails an ongoing surveillance of volume of procedures related to clinical privileges, quality improvement assessments, and structured training acquired by the individual.

Other licensed personnel undergo competency assessment related to their scope of practice on a biannual basis as well. Competency assessment is an important aspect of those involved in direct patient care or those who perform technical duties that have an impact on

direct patient care such as laboratory services, pharmacy, radiology, etc. Baseline technical competence can be acquired or refreshed through nationally recognized programs used locally by designating some providers to become trainers in these programs. Examples of these programs include Basic Life Support, Advanced Cardiac Life Support, Advanced Trauma Life Support, Pediatric Advanced Life Support, and Advanced Life Support for Obstetrics, Neonatal Resuscitation, Fetal Heart Monitoring Principles and Practices, and Critical Incident Stress Debriefing. In addition, the current emphasis on safety includes extensive ongoing training and operationalization of the concepts through specified procedures that are covered in the Patient Safety discussion later in this report.

National Practitioner Data Bank Reporting

The DoD Risk Management Committee monitors reports to the National Practitioner Data Bank (NPDB). The DoD Risk Management (RM) Committee consists of senior staff from the:

- DoD/Health Affairs,
- Three Services,
- DoD Office of the General Counsel,
- Judge Advocate General Corps officers representing the Surgeons General of the three Services;
- Department of Justice, and,
- Armed Forces Institute of Pathology Legal Medicine Division.

The major activities of the RM Committee have been:

- Providing oversight for the DoD participation in the National Practitioner Data Bank (NPDB); and,
- Monitoring the External Peer Review Program of certain DoD malpractice cases through the National Quality Monitoring Contract currently held by the Keystone Peer Review Organization (KePRO).

The NPDB is a central repository, operated by the Health Resources and Services Administration of the Department of Health and Human Services (DHHS), of information about healthcare practitioners regarding malpractice payments, adverse actions (licensure, privileges, professional review, U.S. Drug Enforcement Administration (DEA) actions), and

licensing boards only convene three or four times a year, which creates an unavoidable lag time for licensure.

The remaining unlicensed physicians are either physicians in training beyond PGY-2 (112 and 80), those in fellowship training (25 and 11), a few residency trained physicians (10 and 3), and 2 physicians who only possess the special Oklahoma license, which is not acceptable for practice under Department guidance. These latter 2 physicians no longer practice clinical medicine but have successfully contested attempts to administratively separate them (through a show cause board) from their respective Services.

Finally, it should be emphasized that no unlicensed physician is providing independent medical care to DoD beneficiaries. Licensed attending physicians supervise those who are unlicensed but still in training. Those physicians who are unlicensed, but not in training, can only provide medical care under a defined plan of supervision by a licensed physician and monitored by the credentials office at the military treatment facility (MTF).

Board Certification Rates for TRICARE MHS Military Physicians

As noted above for dentists, board certification is not a DoD requirement for physicians. Figure 1 depicts the board certification rates of TRICARE MHS physicians for fiscal years 2000 and 2001. The rate calculation is based on a denominator of all active duty physicians who were fully trained and qualified during the FY 2000 and 2001 timeframe. Physicians in training, as well as general medical officers, flight surgeons and undersea medicine physicians, who have not completed residency training, are excluded. Of physicians eligible for board certification in 2000, 92 percent attained this level of professional recognition. In 2001, the board certification rate was 90 percent. These rates are slightly better than the national rate reported by the American Medical Association.

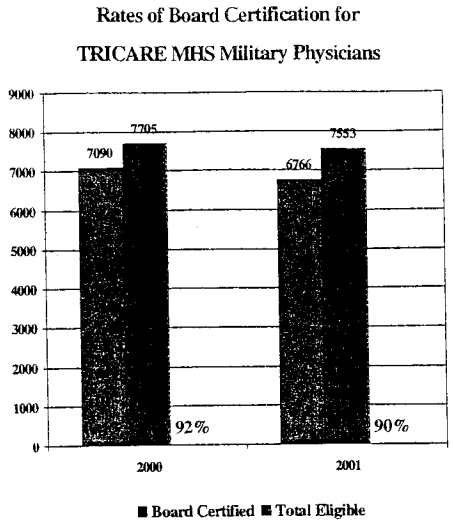

FIGURE 1- Board Certification of TRICARE MHS Military Physicians

Graduate Medical Education (GME) Accreditation

The Accreditation Council for Graduate Medical Education (ACGME) is the professional organization responsible for the accreditation of nearly 7,800 residency education programs. Residency, the period of clinical education in a medical specialty that follows graduation from medical school, prepares physicians for the independent practice of medicine. In conjunction with the standards for accreditation, twenty-six specialty specific committees, known as Residency Review Committees (RRCs) review programs for accreditation.

All TRICARE MHS GME programs for which an accrediting agency exists (205) are accredited by the ACGME. Clinical Pharmacology, Radiology Imaging, Hyperbaric Medicine, Faculty Development, and Developmental Pediatrics programs have no accrediting agencies. At the time of this data collection, fifteen programs were awaiting the results of their most recent evaluations. The distribution of length of accreditation for the various programs is depicted in Table 4. The table demonstrates that 75 percent of DoD GME programs have received accreditation for 4 or 5 years duration; nearly 50 percent achieved the maximal length of accreditation of 5 years.

TABLE 1: Dental Licensure Status FY 01

	Army	Navy	Air Force
Total Dentists	1000	1337	1015
Dentists with a State License	987	1327	1004
AEGD-1* residents without a license	5	10	8
Dentists (less than 1 year on AD) without a license (non-AEGD-1)	8	0	3

Data Source: The Services' Dental Corps

**AEGD –1 = Advanced Education in General Dentistry one-year residency program*

Board certification is not a DoD requirement. Board certification pay is, however, an incentive offered to healthcare providers including dentists. Only dentists who have completed post-graduate training are eligible for board certification. Table 2 displays the board certification rates by Service for TRICARE MHS dentists at the end of FY01.

TABLE 2: Dental Board Certification Status FY01

	Army	Navy	Air Force	DoD Totals
Total Dentists	1000	1337	1015	3352
Dentists in Residency Training	156	92	134	382
Dentists With Completed Residencies	662	453	417	1532
Board Certified Dentists (of those who completed residencies)	354 (53.5%)	239 (52.7%)	287 (68.8%)	880 (57.4%)

Data Source: The Services' Dental Corps

The majority of dentists in civilian practice in the United States are not residency trained, and, therefore, they are not board certified as specialists. In contrast, substantial proportions of military dentists are either in, or have completed, residency training (Army - 81.8 percent; Navy - 40.7 percent; Air Force - 54.3 percent). Of those TRICARE MHS dentists who have completed residency, 57.4 percent are board certified in a dental specialty. The high board certification rates for TRICARE MHS dentists are noteworthy.

Medical Licensure

DoD Directive 6025.13, "Clinical Quality Management Program (CQMP) in the Military Health Services System (MHSS)" July 20, 1995, requires that all physicians, regardless of military or civilian status, practicing in military facilities must obtain and retain at least one current, valid, unrestricted state medical license as a condition of practice.

The aggregate data for FY 2000 and 2001 are portrayed in Table 3. The data includes physicians with full valid unrestricted licenses or approved waivers as well as the categories of physicians who possess neither.

TABLE 3 – Physician Licensure

DoD	FY 00	FY 01
Physicians on Active Duty (AD)	12277	12048
AD physicians with unrestricted license	9548	9587
AD physicians with waiver	810	936
AD physicians no license	1571	1314
Post Graduate Year -1 (PGY-1)	747	688
PGY-2	504	430
PGY-2 +	112	80
Fellow	25	11
GMOs on AD	105	100
Residency trained	10	3
Special OK License	2	2
Other	1	0

Following graduation from medical school, there are two general requirements prior to licensure as a physician:

- Successful completion of at least 12 months in a graduate medical education (GME) program accredited by the Accreditation Council on Graduate Medical Education (ACGME); and,
- Successful completion of all three parts of the national licensing exam.

Ten states (Connecticut, Illinois, Maine, Michigan, New Hampshire, New Mexico, Pennsylvania, South Dakota, Utah, and Washington) require 24 months in a GME program, and Nevada requires 36 months in a GME program. Even under optimal circumstances, it is difficult to secure a license until immediately after Post Graduate Year-1 (PGY-1). The vast majority of DoD physicians without a license are in one of the following categories:

- Serving in their first post graduate year (PGY-1) and are, by definition, not eligible (747 and 688 for FY00 and FY01 respectively);
- Serving in the year PGY-2 (504 and 430 for FY00 and FY01, respectively); or,
- Serving as a general medical officer (GMO) in an operational medicine capacity, (105 and 100 for FY00 and FY01, respectively).

Although there is a decline in the number of unlicensed PGY-2 physicians and new GMOs, there will always be some unlicensed physicians. This is due to the fact that many

Definition

Quality in Health Care is defined as "the degree to which healthcare services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

More specifically, the services provided will be safe, effective, patient-centered, timely, efficient and equitable. (as outlined by the Institute of Medicine[2] and contained in Appendix A). Additionally, the healthcare system emphasizes the following principles:

- Accountability – The healthcare system is responsible to healthcare providers, military leadership and beneficiaries, and places an inherent value on the scientific measurement of individual and system performance characteristics, providing timely relevant feedback in a continuous fashion.
- Continuity of care – The healthcare system assures that care is provided by professionals whose commitment extends beyond the individual patient encounter or incident of healthcare delivery and encompasses a continuum of concern and care extending indefinitely.
- Quality improvement – The healthcare system employs strategies to continuously study and improve the processes and outcomes of providing healthcare services to meet the needs of individuals
- Medical readiness – The healthcare system fields a uniquely trained, equipped, and qualified team to meet the health needs of the fighting forces anytime, anywhere, and is capable of projecting military healthcare forces worldwide to advance our national security interests.

Report Structure

The statutory requirements are addressed below by dividing the report into three major areas of focus: the TRICARE MHS foundation for providing high quality care, performance and improvement initiatives that address clinical outcomes and processes of care, and the beneficiaries' perspectives on how well the system provides care.

Foundation for Providing High Quality Care

This section of the report describes the wide array of structural components of quality assurance and risk management in place to ensure quality health care under the Defense Health Program across the TRICARE Military Health System (MHS). The discussion below relates to the healthcare provided via the TRICARE MHS direct care system of military hospitals and clinics except where otherwise annotated.

Staff Credentials and Qualifications

The most essential resources in healthcare delivery are qualified healthcare providers. The Defense healthcare manpower needs are met through recruitment, attractive educational opportunities and a variety of scholarships. To ensure a continuous flow of available providers, the Services offer a wide array of Graduate Medical and Dental Education (GME/GDE) opportunities. These Graduate Education programs include post-doctoral work in specialized areas in programs commonly called 'residencies'. The attainment of a degree in medicine or dentistry, or the other healthcare professions is just the beginning of the process. The next step is licensure acquired by passing an initial standardized examination and maintaining the license biannually. In order to practice as an independent provider, the Department requires providers to have a full 'unrestricted' license without any limitations on the scope of practice ordinarily granted to other physicians for a similar specialty by the jurisdiction that granted the license.

There are two major difficulties regarding licensure for new providers. The first is the requirement by some states to have completed two years of post-graduate training prior to consideration for a full license. Another is the timing of the exam cycle, which may conflict with either assignment orders for a general medical officer, or the recruitment and indoctrination of a new officer. In either case, this issue is handled with a time-limited plan of supervision.

Dental Licensure and Board Certification

Dentists who do not possess a license work under a defined plan of supervision by a licensed dentist and monitored by the credentials officer at the facility. Dental licensure data are presented in Table 1. Following graduation from dental school, dentists may be commissioned as Dental Officers without a state dental license. DoD requires dentists, however, to obtain a dental license within the first year of active service.

Report to Congress
Quality of Health Care Furnished under the DoD Health Care Program

Background

In 1998, the Institute of Medicine established the Committee on the Quality of Health Care in America. Since then this committee issued two reports, *To Err is Human: Building a Safer Health System* and *Crossing the Quality Chasm*. These reports expounded on the need for fundamental reform of health care to ensure that all Americans receive care that is safe, effective, patient centered, timely, efficient, and equitable. The Committee on the Quality of Health Care in America recommended the following 'rules' for health care organizations, clinicians, and patients to work together to redesign the following health care processes:

- Care based on continuous healing relationships;
- Customization based on patient needs and values;
- The patient as the source of control;
- Shared knowledge and the free flow of information;
- Evidence-based decision making;
- Safety as a system property;
- The need for transparency;
- Anticipation of needs;
- Continuous decrease in waste; and,
- Cooperation among clinicians.

These 'rules' are consistent with the DoD commitment to continuous improvement in quality care.

Statutory Requirement

Section 723 of the National Defense Authorization Act for Fiscal Year 2000, Health Care Quality Information and Technology Enhancement, requires an annual report to Congress.

> "(e) ANNUAL REPORT- The Assistant Secretary of Defense for Health Affairs shall submit to Congress on an annual basis a report on the quality of health care furnished under the health care programs of the Department of Defense. The report shall cover the most recent fiscal year ending before the date the report is submitted and shall contain a

discussion of the quality of the health care measured on the basis of each statistical and customer satisfaction factor that the Assistant Secretary determines appropriate, including, at a minimum, a discussion of the following:

(1) Health outcomes.

(2) The extent of use of health report cards.

(3) The extent of use of standard clinical pathways.

(4) The extent of use of innovative processes for surveillance."

Establishment of the TRICARE Clinical Quality Forum

In response to the above legislation, the Acting Assistant Secretary of Defense for Health Affairs and the Executive Director, TRICARE Management Activity supported the establishment of the TRICARE Clinical Quality Forum (TCQF) in the summer of 2001. The Forum has oversight responsibility for clinical quality assessment programs across the TRICARE Military Health System (MHS). The Forum's primary responsibility is to monitor and assess the quality of health care provided to Department of Defense beneficiaries and to provide recommendations to senior leadership by identifying opportunities for improvement or enhanced oversight of clinical quality initiatives and programs. The TRICARE Clinical Quality Forum's assessment of healthcare quality includes a focus on:

- Ensuring that the quality assurance and risk management foundations that support high quality care are established and robust;
- Monitoring the clinical performance and improvement of the TRICARE MHS with respect to clinical outcomes and processes of care; and,
- Assessing the beneficiaries' perspectives on how well the system provides care.

Definition of Quality Health Care

One of the first tasks tackled by the TCQF was the development of a definition of quality. The definition of quality health care adopted by the TRICARE Clinical Quality Forum (TCQF) reflects elements of definitions already existent in the medical literature, specifically in publications by the Institute of Medicine, the Joint Commission on Accreditation of Healthcare Organizations and the Center for Quality (Health Resources and Services Administration). The definition below encompasses specific elements developed by such resources as modified by the TCQF.

cervical cancer screening for active duty women, and for breast cancer screening for active duty women.

TRICARE MHS military hospitals and clinics are in compliance with a Department directive to post facility specific 'report cards' in a prominent location. Many facilities have also posted these report cards on their facility websites.

Beneficiaries' Perspective on Quality of Care

Multiple surveys are described in the report. The aggregate satisfaction with TRICARE over time is increasing and approaching the civilian benchmark. While the regional view of satisfaction indicates that the beneficiaries in the most mature regions (those with the longest duration of MCSCs) are the most satisfied; in terms of enrollment status, those enrolled in Prime are more satisfied than beneficiaries who use the Extra or Standard options. The retired active duty beneficiaries are more satisfied with their health plan than the active duty members or their dependents. The ratings of the MHS providers by the beneficiaries are also high.

The most recent Customer Satisfaction Survey indicates that the satisfaction with ambulatory medical care in MTFs is higher than the civilian benchmark. Most beneficiaries were either 'very satisfied' or 'completely satisfied' with the care they received at the MTFs. The findings were similar for those beneficiaries who used purchased care.

The inpatient care survey showed higher satisfaction with medical and surgical care than the civilian benchmark but a lower level of satisfaction with patient-centered aspects of obstetric care in the MTFs. A system-wide examination of the provision of obstetric care, currently underway, should result in much improved patient satisfaction.

An important population health finding surfaced in the Health Related Behavior Survey. Over the last 22 years, there has been a downward trend in the use of cigarettes and a leveling off of heavy alcohol use. These data are derived from the DoD wide survey done every four years.

Communicating with our beneficiaries and providing customer service have been enhanced by a number of new programs. The Debt Collection Assistance Officer Program was established in 2001. At the central TRICARE MHS office alone, over 3,100 cases have been handled.

The Beneficiary Counseling and Assistance Coordinator program established full time positions in Lead Agent offices and within MTFs to assist beneficiaries with benefit options and reliable point of contact to address their concerns.

The expansion of benefits to the Medal of Honor recipients and their families was established through identification of a point of contact at each MTF and direct mailing of information to these MOH recipients and their families.

Established in May 2001, the Worldwide – TRICARE Information Center has fielded 1,564,710 phone calls from May 2001 through December 2001. A live non-recorded representative who stays on line with callers until the beneficiary's questions are answered distinguishes this system.

The appendices contain background information about the JCAHO ORYX® measures instituted as of July 2002, the TRICARE MHS Fraud and Abuse web page, the fraud and abuse data collection program, and the functional features of the Population Health Operational Tracking and Optimization system.

It is our view that we have a solid foundation for quality, promising outcomes to date, and methods to address areas that require more focus. As our maturing information management systems come on line, we are confident that we will enhance the quality of health care delivery for our beneficiaries.

providers capable of providing high quality care under all readiness conditions. Federal requirements such as compliance with National Practitioner Data Bank reporting and laboratory accreditation are discussed. Clinical Research programs fully meet all federal regulations and Departmental directives regarding the protection of human subjects. Exploration into the areas of computerized tools such as the Problem-Knowledge Couplers® and the Health Evaluation Assessment Review are progressing well. The TRICARE Military Health System (MHS) of military hospitals and clinics continues to achieve highly favorable Joint Commission of Accreditation of Healthcare Associations (JCAHO) grid scores compared with the private sector.

Unique to the TRICARE MHS is our partnership with large regional Managed Care Support Contractors, which enables us to expand the opportunities for high quality health care delivery. To ensure consistent monitoring of these large commercial enterprises, the National Quality Monitoring Contract, awarded to KePRO, focuses on a wide spectrum of quality management activities. These activities include validating utilization management decisions, serving as an external level of appeal denials made by the various programs funded by the Department (MTFs), Designated Providers, and the Managed Care Support Contractors, and providing peer review of medical records to explore any quality of care concerns.

Over the five option years of the NQMC, the reviewers discovered that approximately eighteen percent of the records contained potential quality concerns based on the initial records they received. These concerns are further analyzed by Regional Lead Agent Staff and the associated Managed Care Support Contract quality staff. During this same timeframe, the length-of-stay determination concerns have decreased to 2.2 percent, a decrease of 39 percent. Similarly the rate of admission denial concerns has decreased from 10 percent to 4.8 percent, a 52 percent decrease. As this program has matured, the contractor response to KePRO has improved 307 percent in timeliness. Appeals are upheld approximately 50 percent of the time. Contractor agreement with KePRO is overall at a high of 86 percent. Given the complexity of the art and science of medicine and the diverse experience of our providers, this is a respectable initial benchmark for concurrence with KePRO.

KePRO also assists the Department in conducting onsite surveys of mental health facilities, an aspect of care long recognized by Congress as needing structured oversight. Currently, of all the cases reviewed by KePRO, documentation issues, particularly in mental health records, continue to raise the most concern.

At the regional level, the network quality assessment program functions to oversee the verification of credentials and validation of current competence and to monitor beneficiary grievances, quality performance and quality review studies.

The full deployment of the Pharmacy Data Transaction Service (PDTS) was a landmark event for patient safety in 2001. The PDTS improves the quality of the DoD prescription service worldwide and enhances patient safety by reducing the likelihood of adverse drug-drug interactions, therapeutic drug overlaps, and duplicate treatments.

Fiscal year 2001 marked the initial Department Instruction establishing the Patient Safety Program, the establishment of the MHS Patient Safety Center located at the Armed Forces Institute of Pathology, a Patient Safety Council, and a Patient Safety website. These initiatives are integrated with multiple nationally recognized civilian and federal institutions including the Department of Veterans Affairs.

Performance Improvement – Clinical and Process Outcomes

The Program Integrity program is an important section of the report because it addresses the value of oversight and prospective monitoring of health care fraud. In liaison with multiple federal agencies, the TRICARE MHS recoupment of $12.8 million dollars not only gives an excellent return on investment; it gives the TRICARE MHS confidence that we protect our patients from harm.

The TRICARE MHS is closing in on the goal of 95 percent readiness in dental health. A full discussion of the dental initiatives covers direct care as well as the newer purchased care programs and the accompanying high levels of satisfaction with dental care.

The active development of clinical practice guidelines in conjunction with the VA and the baseline monitoring of data related to these guidelines through the TRICARE MHS National Quality Management Program has shown that overall: the TRICARE MHS exceeds the HEDIS® 90th percentile in the appropriate use of asthma medications, in all areas of diabetes test compliance with the exception of lipid testing, the rates of

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(1) Health outcomes.

(2) The extent of use of health report cards.

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(4) The extent of use of innovative processes for surveillance."

Overview of Effort

This report describes the establishment of the TRICARE Clinical Quality Forum with a Charter, the definition of quality of health care, and the oversight of the three dimensional view of quality: the foundation for providing high quality care, performance improvement efforts regarding clinical and process outcomes, and beneficiaries' perspectives on quality of health care they receive. The required elements of this report noted above are integrated within the context of the three dimensional view of quality.

Foundation for Providing High Quality Care

The primary foundation for high quality lies in the selection, preparation, and retention of highly qualified providers. This section of the report describes the process of establishing staff credentials and licensure for providers and the use of graduate medical or dental education to ensure appropriate training programs to sustain a cadre of

PI	Program Integrity
PQI	Potential Quality Issue
PSWG	Patient Safety Working Group
QI	Quality Issue
RM	Risk Management
RRC	Residency Review Committees
RTC	Residential Treatment Center
SD	Standard Deviation
SUDRF	Substance Use Disorder Rehabilitation Facility
TCQF	TRICARE Clinical Quality Forum
TDP	TRICARE Dental Program
TED	TRICARE Encounter Data System
TOPS	TRICARE Operational Performance System
TMA	TRICARE Management Activity
TMAC	TRICARE Maximum Allowable Charge
TMIP	Theater Medical Information Program
TOPS	TRICARE Operational Performance Statement
TRDP	TRICARE Retired Dental Program
TSP	TRICARE Senior Prime
UB-92	Uniform Billing Form 1992 Version
USC	United States Code
USUHS	Uniformed Services University of the Health Sciences
WPS	Wisconsin Physician Services
W-TIC	Worldwide - TRICARE Information Center

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FHP	Force Health Protection
FT	Fort
FY	Fiscal Year
GDE	Graduate Dental Education
GME	Graduate Medical Education
GMO	General Medical Officer
HBA	Health Benefits Advisor
HCSDB	Health Care Survey of Department of Defense Beneficiaries
HCSR	Health Care Service Record
HEAR	Health Evaluation Assessment Review
HEDIS	Health Employer Data Information System
HIPAA	Health Insurance Portability and Accountability Act
HIPDB	Health Integrity and Protection Data Bank
HOS	Health Outcomes Survey
HPA&E	Health Program Analysis and Evaluation
HQIRP	Health Quality Initiatives Review Panel
HRBS	Health Related Behaviors Survey
HTN	Hypertension
ICD-9-CM	International Classification of Diseases, 9th Revision Clinical Modification
ICMP-PEC	Individual Case Management Program for Persons with Extraordinary Conditions
ICS	Inpatient Care Survey
IFMC	Iowa Foundation for Medical Care
IG	Inspector General
IHI	Institute for Healthcare Improvement
IOM	Institute of Medicine
IPT	Integrated Project Team
IRB	Institutional Review Boards
JCAHO	Joint Commission on the Accreditation of Healthcare Organizations

KePRO	Keystone Peer Review Organization
LDL	Low-Density Lipoprotein
LDL-C	Low-Density Lipoprotein – Cholesterol
M	Million
MCO	Managed Care Organization
MCSC	Managed Care Support Contractor
MEPRS	Medical Expense and Performance Reporting System
Mg/dL	Milligrams per deciliter
MH/CD	Mental Health/Chemical Dependency
MHS	Military Health System
MHSPSC	Military Health System Patient Safety Center
MHSPSR	Military Health System Patient Safety Registry
MOU	Memorandum of Understanding
MTF	Military Treatment Facility
NCQA	National Committee for Quality Assurance
NHCAA	National Healthcare Anti-Fraud Association
NPDB	National Practitioner Databank
NQF	National Quality Forum
NQMC	National Quality Monitoring Contract
NQMP	National Quality Management Program
NRC	National Research Corporation
OASD(HA)	Office of the Assistant Secretary of Defense for Health Affairs
OB/GYN	Obstetrics/Gynecology
P or p	Probability
PCM	Primary Care Manager
PCS	Purchased Care Survey
PDTS	Pharmacy Data Transaction Service
PGBA	Palmetto Government Benefits Administrators
PGY	Post Graduate Year
PHOTO	Population Health Operational Tracking and Optimization Program
PHP	Partial Hospitalization Program

Acronyms

Used in this Report

ACGME	Accreditation Council on Graduate Medical Education
ACOR	Alternate Contracting Officer Representative
AD	Active Duty
ADSM	Active Duty Service Member
AFB	Air Force Base
AFIP	Armed Forces Institute of Pathology
AHRQ	Agency for Healthcare Research and Quality
ALOS	Average Length of Stay
AMEDD	Army Medical Department
AMI	Acute Myocardial Infarction
ASD(HA)	Assistant Secretary of Defense for Health Affairs
AUSA	Assistant United States Attorney
BCAC	Beneficiary Counseling and Assistance Coordinator
BP	Blood Pressure
CABG	Coronary Artery Bypass Graft
CAHPS	Consumer Assessment of Health Plans
CAP	College of American Pathologists
CAP	Corrective Action Plan
CCQAS	Centralized Credential Quality Assurance System
C&CS	Communication and Customer Service
CDR	Central Data Repository
CFR	Code of Federal Regulations
CHCS	Composite Health Care System
CID	Clinical Investigation Department
CIP	Clinical Investigation Program
CLIA	Clinical Laboratory Improvement Act
CLIP	Clinical Laboratory Improvement Program
CMAC	CHAMPUS Maximum Allowable Charge

CMS	Center for Medicare and Medicaid Services
COE	Center of Excellence
CONUS	Continental United States
CORE	Center for Outcomes Research and Evaluation
CPG	Clinical Practice Guideline
CPS	Clinical Preventive Services
CPT	Current Procedural Terminology
CRDA	Cooperative Research & Development Agreements
CSS	Customer Satisfaction Survey
CY	Calendar Year
DCAO	Debt Counseling Assistance Officer
DCIS	Defense Criminal Investigative Service
DEERS	Defense Eligibility and Enrollment System
DHHS	Department of Health and Human Services
DHP	Defense Health Program
DIST	Decision Support Information Technology
DO	Doctor of Osteopathy
DoD	Department of Defense
DoDD	DoD Directive
DoD/VA EC	Department of Defense/Veterans Affairs Executive Council
DMFT	Decayed, missing, filled teeth
DP	Designated Providers of the Uniformed Services Family Health Plan
DRG	Diagnosis Related Group
DTF	Dental Treatment Facility
DVA	Department of Veterans Affairs
EI/DX	Executive Information/Decision Support
ER	Emergency Room
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FEHBP	Federal Employee Health Benefits Program

Appendix

TRICARE MANAGEMENT ACTIVITY

Report to Congress

Quality of Health Care under the Defense Health Program

During Fiscal Year 2001

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